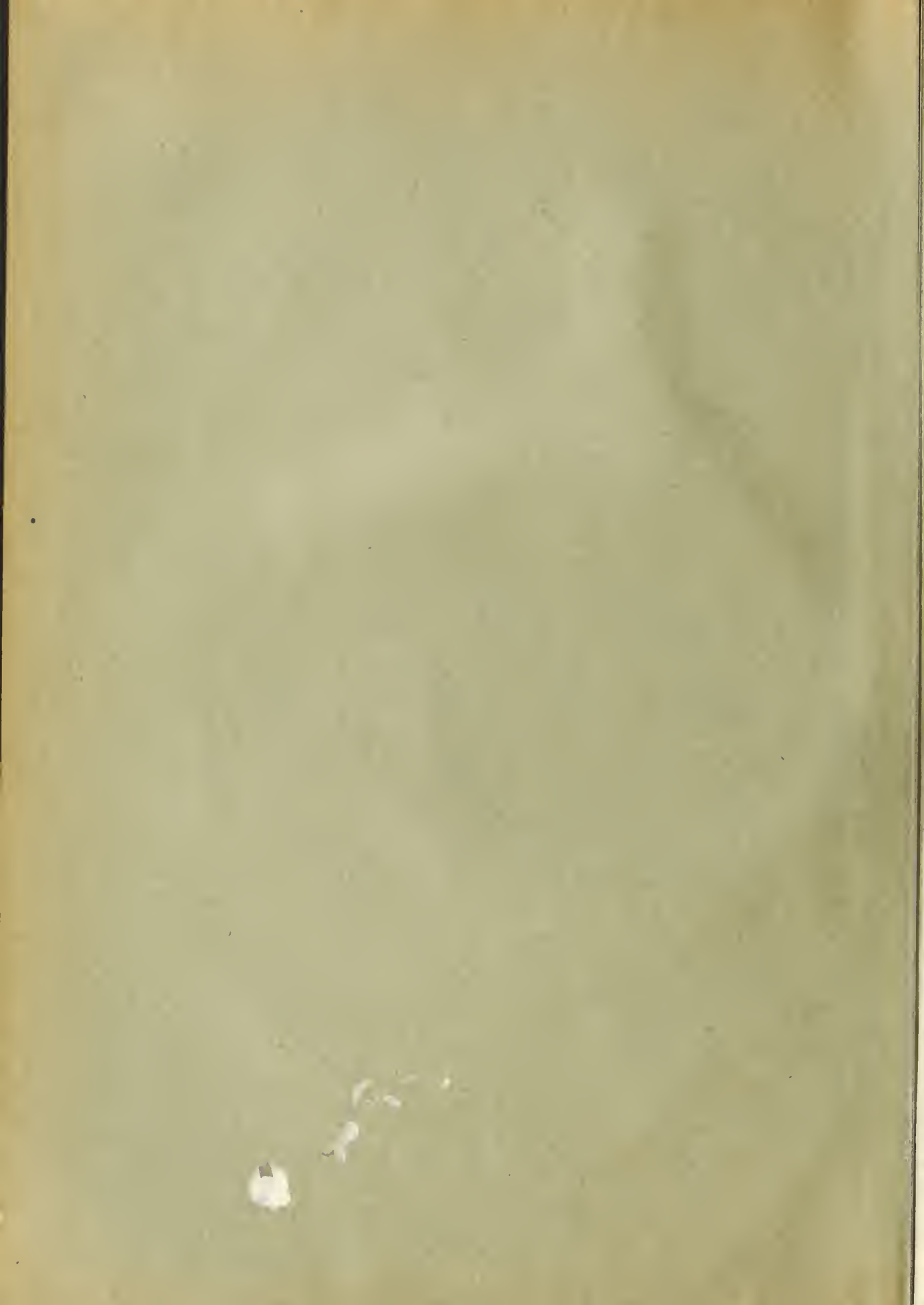


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JANUARY, 1945

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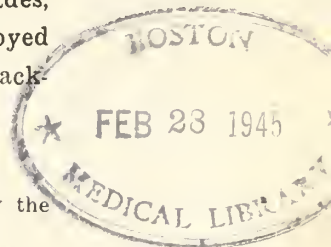
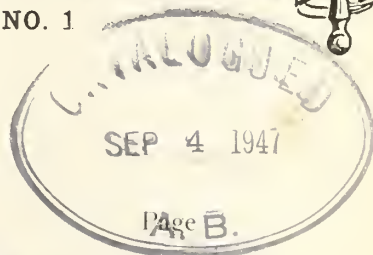
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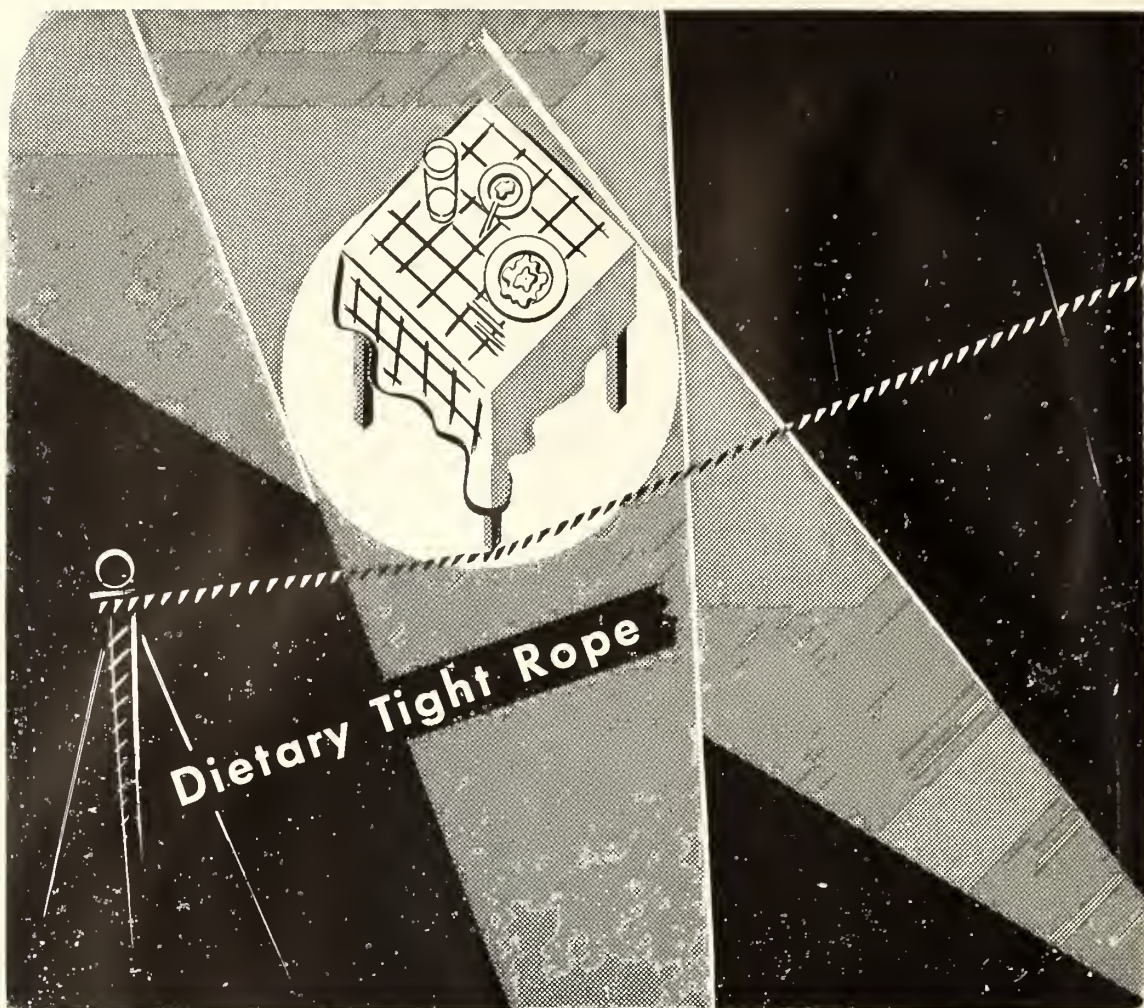
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Medicine After The War

VICTOR JOHNSON, PH.D., M.D.

Secretary, Council on Medical Education and Hospitals American Medical Association
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Numberless uncertainties face the world of tomorrow and the people of America. Everyone in medicine shares these doubts with men and women in all fields of human endeavor. In addition, there are grave problems peculiar to medicine, of special concern to those engaged in medical research, education, and practice. Challenging responsibilities confront medicine, which must be met with resolution and wisdom if medicine is to maintain and strengthen its position in a new and better world after the war.

But, if there are baffling unknowns, let us be equally sure that vastly important *certainities* also lie ahead, certainties that medicine has learned even through the war years, and that provide a sturdy framework about which we may construct the edifice of medicine in the world of tomorrow. The first of these certainties is that medical research will play an increasingly important role, not merely in the laboratory, but in medical education and the practice of medicine as well.

Wartime and Postwar Medical Research

It would be fruitless to recount the practical consequences of medical investigation on our better understanding of man in health and disease and on our ability to control disease. Life has been prolonged and enriched and shorn of much of its ignorance, fear and pain. It is anomalous that even so destructive a catastrophe as the present war has incidentally contributed to these ends.

During the war we have learned that attacks upon unsolved problems are much more effective when teams of investigators from several laboratories work in collaboration. Wartime experience with plasma has tremendously stimulated the organization of blood banks for civilian use, not only for occasional peacetime catastrophes, but in the routine of hospital care. Even the rural physician can be supplied.¹ Blood banks are supplying blood and plasma not only for substitution therapy in shock,

hemorrhage and related conditions but are increasingly serving as centers for the collection and distribution of specific immune plasmas and serums for the therapy of infectious diseases. ^{2, 3} The more effective use of penicillin has resulted from a coordinated research program dictated by war needs and directed by Dr. Chester Keefer. Assisted by the War Production Board, drug houses are now producing much more penicillin in a month than was manufactured in the entire year 1943. We have learned that health is not a local commodity but must, like peace, be maintained on a global scale or all will suffer. The importance of wartime accelerated air transport in health problems is dramatically stressed in a passage of the 1944 annual report of the Rockefeller Foundation.

"In former issues of this Review an account has been given of the successful campaign in Brazil against the dangerous malaria-carrying *Anopheles gambiae* mosquito whose home is in Africa. After high death rates and enormous suffering, and with great labor and cost, it can be said with confidence that the *gambiae* species was eliminated from Brazil.

"The Foundation was therefore disturbed to receive, during 1943, advices from its representatives in Rio de Janeiro that *gambiae* mosquitoes, some of them alive, had been found on planes coming from Accra and Dakar in Africa to Natal. Even more disturbing was the news that five live *gambiae* had been discovered in dwellings near the Natal airport. Incoming planes from Africa are, of course, fumigated both before they leave Africa and before they land in Brazil, but a few mosquitoes were evidently able to stow away safely in the modern, complicated airplanes. When it is realized that a single fertilized *gambiae* could start a conflagration similar to that which swept north from Natal in the thirties, the danger of the situation becomes apparent.

"Thanks to the efforts of the Brazilian and United States authorities, the immediate situation is now in hand. But it poses a problem of larger

¹Founders day address delivered at the Medical College of the State of South Carolina, Charleston, S. C., Nov. 2, 1944.

significance which cannot be evaded. Around the ports of Africa and deep within the hinterland lie the breeding centers of the *gambiae*. The safety of the Western Hemisphere, which is now within a few hours' flight across a narrow ocean, can no longer be left to the uncertainties of a flit-gun campaign. Modern airplane travel has made old methods and ideas of quarantine completely obsolete."

Much of what has had to be learned about aviation medicine will increase the safety and comfort of postwar flying. Air transport of the wounded has been a major factor in the astonishing reduction in the death rate of battle casualties. We may anticipate that, after the war, the airplane and other means of improved rapid transportation will contribute significantly to problems of distributing medical care. Increasingly, patients will be carried to the physician and the hospital conserving the energies and time of the doctor, and obviating a prodigal construction of hospitals and other health facilities.

The war has also taught us that we must be willing to pay without reservation when there is a "must" job to be done. The construction of guns and the mills to make the steel, of supplies and the factories to produce them, and of ships and shipyards—for these we have freely given of our treasure. We must be equally ready to provide funds for the creative tasks to be accomplished in man's never ending war against death and disease. That war has never commanded a fraction of the boldness of our expenditures and efforts in destroying our human enemies.

In Detroit there is a vast assembly line turning out a Liberator bomber, bigger than a Flying Fortress, every hour, at a cost of about a third of a million dollars. A day's work in a single factory equals the warplanes shot down in one major raid. It would also pay a year's tuition for practically every medical student in all our medical schools. It would balance the annual budget in a score of medical schools. It would more than support all the cancer research in this country for years. One or two Liberator bombers shot down from the many thousands of planes that participated in the Normandy invasion is all we care to pay annually for cancer research; yet the daily death rate from cancer (400) greatly exceeds the daily deaths (300) in the first days of the Normandy invasion.

One bomber equals months of cancer research, a year's legislative appropriation for a state medical school, or the gate receipts of one major football game. The war shames our timid support of research in our fight against disease, which continues to exact its appalling toll of unhappiness, suffering and death, year by year, in war and peace. We may be sure, we must *make* sure, that research will vastly expand after the war, so that there may be an insulin, a liver extract, or a penicillin for hypertension, coronary disease, and the common cold. Science, said Julian Huxley, will continue to be the chief

agency of man's control over his own destiny.⁴

But research, the scientific method, is more than a technique for controlling nature. It is a frame of mind, an approach to the problems of life, a design for education. In the Herbert Spencer Memorial Lecture at the University of Oxford in 1942, Professor A. G. Tansley insisted that "scientific culture . . . must take its place on equal terms beside literary and artistic culture."⁵ If a knowledge of political history is essential to education, so also is a familiarity with the broad sweep of history written in the rocks of geology. The economics of nations and classes are no more basic than the interdependent plant and animal relationships in the "web of life" emphasized in ecology. Faraday's brilliant but simple reports on his studies of electricity, and Harvey's accounts of his experiments on the circulation, are no less exciting culturally than are the classics of English literature and poetry. Too many people, including teachers, regard science as little more than weighing and measuring, test tubes and galvanometers. Science is easily made dull and uninspiring. It can be a liberal education, at all levels: the high school, the university, the medical school.

MEDICAL EDUCATION

Among the postwar certainties we may count on, is that medical education will become increasingly important as the foundation upon which medicine and the nation's health rest. The original call of the Medical Society of the State of New York, which led to the formation of the American Medical Association in 1847 stated that "it is believed that a national convention would be conducive to the elevation of the standard of medical education in the United States," and "there is no mode of accomplishing so desirable an object without concert of action on the part of the medical societies, colleges and institutions of all the states."

In 1905, Dr. Arthur Dean Bevan reported to the first annual conference of the Council on Medical Education of the American Medical Association: "Your committee finds . . . that the American Medical Association was founded for the purpose of elevating . . . medical education in the United States. Your committee believes that this is still the most important function of the American Medical Association. . . . With the new reorganization of the Association into a compact . . . body, representing the medical profession of each county and state, your committee feels that the American Medical Association has become the best national instrument to . . . elevate medical education."

The close interdependence of medical education, medical care, and medical research is asserted much more frequently than it is understood. Medical education has no meaning except as it conceives and meets problems of medical care, not simply in the control of illness in a given patient, but in fostering an understanding of health as a public asset, and of disease as a foe to be met not only in the

patient but in research in the clinic and the laboratory.

There are very naive concepts regarding the role of research in schools of medicine. Trustees say, "Our funds are so limited that they must be employed for teaching; we cannot support research." Presidents say, "Our aim is to produce practicing physicians; we leave research to the Rockefeller Institute, Harvard, the Mayo Clinic." Instructors say, "Teaching occupies my full time and energies. I am employed to teach. I have neither funds, facilities, nor time for research."

In medical education good teaching cannot be divorced from research. Medicine is a complex of experimental sciences and arts, and it cannot be understood unless research is also understood. The student who goes entirely through his medical course learning all the material placed at his disposal, without becoming especially interested in one of the many unknowns he encounters in his studies, has missed something fundamental in his education and vital to his later practice of medicine. The teacher who teaches what is known, however excellently, is remiss as a teacher unless he arouses an impelling curiosity in his students regarding the unknown. This he can scarcely do unless he himself has been sufficiently stimulated to attempt to solve some problem at which he has at least worked earnestly during some of the time remaining after the responsibilities of classroom, laboratory and clinic instruction have been met. I do not mean that all medical schools should try to develop ambitious and elaborate research programs. That is impossible even with normal peacetime resources of funds and men. I do mean that the school which considers research and teaching as separate activities, and the teacher who is not inwardly driven to do even a modest amount of research, will only partially accomplish their goals of teaching medicine. With most of our institutions and most of our teachers and most of our students, by far the greater emphasis and effort must necessarily be upon mastering the known in medicine. But there must be a leavening of research to convert the dough into bread.

A well-balanced medical school program if it but carries only the flavor of research, will produce men better qualified to meet the complex problems of medical practice, and better attuned to the progress which will continue to be made in the understanding and control of disease by men who devote most if not all their energies to unsolved problems in biology and medicine.

As unjustifiable as the artificial separation of the medical school professor's duties into those of teaching and research, is the equally indefensible separation of the subject matter of medicine into the obsolete watertight compartments known as departments. Our philosophy of medical education states that man's body, in health and disease, may be divided into its anatomy, its biochemistry, its phy-

siology, its pathology, and so forth. This highly artificial subdivision of our subject matter was not planned. It was an accident—an accident of growth. At first there was little more than Anatomy in the curriculum. Anatomy gave birth to daughter sciences including Physiology, which in turn produced the offspring, Physiological Chemistry, and later still another lusty infant, Biophysics. Departments just grew, and the departmental system of instruction just happened. There has resulted a scramble for student time, in which every hour of student time not specifically accounted for in the curriculum is counted as fair game. The department with the most aggressive hunters captures these hours. The successful department is that which has acquired the most hours into which it then crams a maximum of detail whether or not it is relevant.

A more rational and time-conserving program of study is one in which there are no Anatomy, Physiology or Pathology "courses" at all. Instead, the Anatomist, the Physiologist and the Pathologist collaborate in presenting an integrated picture of the body in health and disease, in which accidental repetition is eliminated, and planned repetition incorporated when required. I have participated in such a plan at another level of education, the teaching of Biology to college students. The course is a collaborative enterprise in which lectures, discussions and laboratory exercises are given by twenty men from ten different departments, including medicine and surgery. The departmental affiliation and special interests of each instructor are subordinate to the subject-matter of the year's course—Biology. Frequent discussion and criticism of each other by participants in the course have led to a presentation of biology at this level which is far more effective than is possible without such close collaboration. The success and widespread adoption of such plans in college teaching are stimulating medical educators to think along similar lines. There would be an improved selection of the contents of the medical curriculum, since the material presented by each instructor would be subject to the scrutiny of his colleagues in other fields. The student would better grasp the total picture of medicine, since each instructor would integrate his subject with that of his colleagues in a far more effective manner than is possible under the traditional departmental course system. Student time would be conserved for reading, reflection, investigation, and the pursuit of special interests.

In the first two years of medical school, conjoint courses should be given by committees consisting of members of several basic science departments. The curriculum might be somewhat as follows:

1. First quarter (freshman year)

Introduction to Medicine. Structure and chemistry of cells, tissues, and common parasites; the reactions of tissues to foreign agents; gross anatomy of the extremities, elementary neuro-muscular physiology; reproduction, growth and senescence. Given

by a committee with representatives of each of the following departments: Anatomy, Bacteriology, Biochemistry, Pathology, Physiology, Medicine,* Surgery,* Pediatrics,* and Obstetrics.*

*In each of the basic science conjoint courses, appropriate clinical material (lectures, demonstrations, X-ray, etc.) should be included, not to make clinicians of medical students prematurely, but to assist in the student's grasp of the basic sciences. Also appropriate preclinical material should be included in the clinical work of the student.

2. Second quarter (freshman year)

The Internal Environment: Chemistry of blood and regulation of its composition; coagulation; hemorrhage; morphology, formation, abnormalities (anemias, etc.) of formed elements. Given by: Anatomy (histology), Biochemistry, Pathology, Medicine.

3. Third quarter (freshman year)

The cardiovascular, renal, and respiratory systems. The chemistry, physiology, histology, gross anatomy and abnormalities of the heart, vessels, circulation, kidneys, and respiratory system; the cardiovascular drugs. Given by Anatomy, Biochemistry, Pathology, Pharmacology, Physiology, Medicine, Surgery.

4. Fourth quarter (sophomore year)

Gastroenterology and metabolism. The histology, physiology, pharmacology, biochemistry and abnormalities of the gastrointestinal tract and metabolism (including endocrine glands). Given by Anatomy, Biochemistry, Pathology, Pharmacology, Physiology, Medicine, Surgery.

5. Fifth quarter (sophomore year)

The Nervous System. Histology, gross anatomy, physiology, pharmacology of the nervous system; medical psychology, abnormalities of the nervous system. Given by Anatomy, Medicine (psychiatry), Pharmacology, Physiology, Medicine, Surgery.

6. Sixth quarter (sophomore year)

Introduction to the clinical work including physical diagnosis, history taking and therapeutics.

Extension of these curricular concepts into the clinical years has already occurred in the modern medical school. In his clerkships, the clinical student does not study Medicine, Surgery or Pediatrics. He studies patients: human beings presenting abnormalities to be understood and controlled. "Pre-clinical" instruction lags far behind. I vividly recall the exhortation of a student—not myself—by an anatomist starred in American Men of Science—not at the University of Chicago—for reading a Biochemistry text in an Anatomy laboratory. As an instructor in the myopic basic medical sciences, I contrast this with the universally practiced interdepartmental consultation service in the clinics. The latter is not merely a more practical approach, but a more rational one as well.

Educational experimentation along these lines is progressing in a few schools—especially in schools with young faculties, not bound by the asphyxiating traditions in American medical education. We do

not know what the outcome will be. The important fact remains: research and experimentation is under way in medical education.

MEDICAL CARE

Scientific experimentation must provide not only the solution of the problems of control of disease and the education of physicians but also it must guide us in determining the forms which medical practice shall take in the future. Medical science plans experiments, measures results and plans further experiments, to the end of greater and greater understanding of man in health and disease. This same spirit must direct us in solving the equally complex problems of man's relationship to his fellows, and the place of medicine in a changing social and economic structure.

We may be sure that changes will come in the forms of medical practice after the war. In facing these problems, we should be impelled by the impartial spirit of inquiry which serves so well in the pursuit of the truth in the medical sciences.

We must recognize the extreme complexity of the problem. To state that doctors are attracted to cities because they can make more money there is a gross oversimplification. Cities provide the essential tools for the practice of medicine, which have been many times multiplied: X-ray equipment and electrocardiographs, laboratory facilities and consultation services, and above all, hospitals.

The economic level in many rural communities, and in many counties in the United States makes it impossible for those communities, unaided, to provide either doctors or the necessary facilities for doctors to carry on their work. But even if all facilities were provided the country physician, problems of distribution of medical care would remain. The doctor demands, in common with his civilized fellows, a life with stimulating social, intellectual and cultural contacts. Good schools, homes, churches, music and comradeship may loom as large in his selection of a community to practice in as income, X-rays or hospitals.

The distribution of medical care is only one aspect of the larger problem of elevating the general economic level of large numbers of our population in peacetime. If unemployment is kept as low as now, and production is maintained at the present level after the war, and dedicated to the welfare of the people, problems of distribution of medical care will be greatly diminished.

Difficult though these problems are, they must be attacked. Here, as in science, experimentation provides the most promising approach. New experiments are being planned almost daily, and the reports are rapidly accumulating. The California Physicians service, under the auspices of the San Francisco County Medical Society, is rapidly increasing the scope of its services. About a year ago, the rate of growth of C. P. S. was about 1000 new members per month. Today, 6000 members per

month are added, although the net gains are less than these figures indicate because of the turnover in employment.

The Prepaid Medical Service in Connecticut is operating on a cash indemnity basis under the auspices of the Connecticut State Medical Society. The Committee on Medical Economics of the Kansas Medical Society is developing a prepayment plan for certain medical services. From Michigan it is reported that "one person in nine in Michigan is covered by Michigan Medical Service Certificates, and one in five by Michigan Hospital Service."⁶

The Missouri State Medical Association has unanimously adopted a plan of prepayment for medical and surgical care in hospitals, to be known as Missouri Medical Service, Inc.

In Nebraska, the House of Delegates of the Nebraska State Medical Society has adopted a resolution providing for the study of insurance plans and organization of such a plan for Nebraska.

Numerous other plans have been in operation, for varying periods, on a state-wide or county basis, under the auspices of the medical profession. This is true in Colorado, Massachusetts, New Jersey, New York, Pennsylvania, Utah, Texas, Kansas, Delaware, and North Carolina. These plans must be looked upon as experiments in the more complete and equitable distribution of medical care.

As in the fields of the more exact sciences these experiments in medical sociology are likely, in some instances, to turn out to be poorly conceived, and often the results may be difficult to interpret. But the all-important fact remains: experiments are in progress, and we may hope that such experiments in the distribution of medical care may be as fruitful as those upon insulin and diabetes, liver and anemia, and penicillin and infections. Roger Lee, president-elect of the American Medical Association, discussing this problem before the Pepper subcommittee on Wartime Health and Education, declared that "it was hard to improve the phraseology of a

British recommendation: 'There should be initiated, by arrangement and agreement between the government and the profession, organized experiments in the methods of practice, such a group practice, including health centers of different kinds, which should extend to general practitioners hospital units attached to general hospitals. Future developments in group practice should depend on the results of such clinical and administrative experimentation.'"⁷

We are impelled to continue experiments of this kind, as well as experiments in carrying patients to the doctors with their facilities, recalling the air transport of the wounded in battle, instead of struggling to provide doctors and hospitals to every community. We must experiment with travelling clinics and the closer integration of diagnostic, hospital and expert consultation services. Above all, we must experiment rather than design blue prints in the skies; we must follow the methods of science, not the promptings of the emotions. As a Physiologist, I am a devotee of the Science of medicine and of the scientific method as the most promising instrument for the solution of man's problems and of medicine after the war, in the control of disease, the education of physicians, and the provision of adequate medical care for everyone.

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Treating Diabetics With Insulin

WILLIAM R. JORDAN, M.D., RICHMOND, VIRGINIA

I was asked to talk to you about the new things in diabetes and it occurred to me that insulin is tied up with nearly all the advances in diabetes since its introduction by Banting and Best.

There have been modifications in the use of the original regular insulin and modifications in the insulin itself. Different men employ somewhat different methods in using these modified insulins. Many things mentioned by me are not new, but most of them are new to me because my present knowledge is the result of new experiences with them. For example, I thought I knew how the regular insulin acted until I encountered cases of severe insulin resistance. Then I really obtained some new knowledge as far as I was concerned.

There are 4 kinds of insulin. They are regular, crystalline, protamine, and globin. They are marketed in different strengths based on the blood sugar lowering capacity of 1 cc. of the product under certain standard conditions. These concentrations are designated in terms of units so that 1 unit of one strength, such as U-80, will be equal to 1 unit of any other strength, such as U-20. To eliminate the need for figuring the volume needed to equal a certain dose, syringes are sold with scales graduated in terms of the different strengths of insulin. Unfortunately, confusion arises often because one assumes that 1 unit of insulin as marked on a syringe equals 1 unit of insulin regardless of the strength used. This, of course, is false unless the scale used is identical with the concentration of insulin used. I believe it would be better to have a standard syringe marked only in minims which is known to every doctor and could be taught easily to every patient than to continue with our present system. It would then be simple to direct the patient to take so many minims of U-40 or of U-80 insulin of a certain kind. Mistakes of this nature occur daily when a patient changes doctors or buys a new and different syringe. I have known the dose of "10 units" to actually represent 80 units, 40 units, 20 units, 10 units, 25 units, 50 units, and 8 units because of the differences in strengths of insulin and the scales used on different syringes. If you are using U-40 insulin and have directed the patient to take 23 units, she may break the syringe, buy one with a minim scale and take 23 minims or 57½ units which may produce severe insulin reactions. This happens repeatedly even in patients who have used insulin for years. At present I have in the hospital a patient, case No. 1054, who has taken excellent care of herself with insulin for 18 years, and yet she made a similar mistake.

All of us are familiar with the regular insulin which begins to act within ½ hour, tends to produce

The Author:

A graduate of the University of Virginia Medical School (1928) Dr Jordan is now located in Richmond, Va., where he devotes his practice to diabetes.

hypoglycemic reactions in 4 to 5 hours, and finally wears itself out in 7 to 8 hours. The crystalline insulin, or solution of zinc insulin crystals, is comparable in every way except that it lasts for 9 to 10 hours, and I believe it has a little less tendency to produce these sudden reactions. I have used crystalline instead of regular insulin for several years without regret. The protamine insulin is quite different. It begins to act slowly over a period of some hours and continues to exert a relatively uniform and moderate action for 24 hours or more. The smaller doses, such as 10 to 15 units, act much more rapidly and have less duration in my experience. In such small dosage this insulin seems to act more like crystalline insulin, and reactions at noon or before supper result from the breakfast dose. The larger doses, such as 100 units may last 2 or 3 days. One patient, Case No. 218, had a blood sugar of 55 mg. seventy-two hours after his previous dose of this insulin. The difficulty with this insulin is that it seldom acts strongly enough to take care of a reasonably large meal, and it acts too strongly if no food is taken. Therefore, glycosuria after meals tends to occur, as well as insulin shock in the early morning hours after 8 hours fasting. We try to compensate for the former by using some crystalline insulin and for the latter by prescribing a bedtime lunch of milk and crackers. Reactions with this insulin may simulate those due to the regular insulin, including weakness, trembling, sweating and nervousness. In addition headache and nausea on awakening may be the only manifestations of extreme hypoglycemia due to protamine insulin. Furthermore, although orange juice may give relief as with regular insulin, the maintained action of this insulin will cause a recurrence of symptoms unless a more substantial lunch is not soon taken.

Globin insulin is the newest of the commercial insulins. It represents an attempt to perfect an insulin that combines the strong quick action of the regular insulin with the prolonged effect of the protamine variety. Unfortunately, it seems to have failed in 2 respects. It begins to act too late and it stops acting too soon. The result is that certain patients, especially those with great nocturnal catabolism and little intrinsic insulin, wake up with a high fasting blood sugar. Breakfast pushes this still higher until several hours later the globin insulin

Read before the Dillon, Darlington, Florence, and Marion County Societies, Oct., 1944, Florence, S. C.

given before breakfast finally gets to work and brings the blood sugar down.

I have tried this insulin in 20 odd cases and have not found it very satisfactory. It seems to produce much more pain at the site of injection than the other insulins do. One patient, Case No. 36, discontinued it for this reason after several months of trial. Another stopped it because of insulin reactions occurring without warning at any hour of the day or night until the dose was reduced to the point where the blood sugar was much too high. Apparently its action is variable and influenced by factors beyond my knowledge. I cannot say that I have given it an adequate trial, but I have failed to find evidence that it should replace any other insulin. Mosenthal considers that it acts about 12 to 14 hours and can be used in conjunction with another insulin. If that be true, it should be satisfactory for injection before breakfast and supper without the help of another insulin. I have not found this true.

Now to proceed from the principles to the details of insulin treatment, let's outline our method of regulating a diabetic patient. The foundation of treatment is a uniform daily diet prescribed to control body weight and general health. Three regular meals of approximately equal size are given. Give balanced meals rather than calories, carbohydrate, protein and fat. No one wants to eat a calorie. He wants a good square meal, and he is entitled to it. If he needs more bread, he wants more butter or meat to go with it. Just remember what we all eat and give the patient that kind of a diet without the sweets we consume. Weigh the patient at each visit and increase or decrease his food as we find necessary each month or two. In addition to the 3 meals, milk and crackers are given at bedtime if protamine insulin is used, and fruit is given 3 hours after breakfast if crystalline insulin is needed. If the patient is treated at the office or home, one may wait a week or two, if there is no emergency, to see if the sugar is controlled by diet alone. If control is not thus obtained, office or home cases are then started on insulin which they are taught to give themselves. Changes in the insulin dose are made on the basis of tests of the 24 hour urine sample which the patient is instructed to bring at each visit about 3 days apart. In hospital cases insulin is begun the first day, at which time a dose of 12 to 15 units of protamine insulin is injected as soon as the diagnosis of uncontrolled diabetes is made. The following morning, if no insulin reaction has occurred, the dose is increased 3 units and this is done daily, as long as the daily 24 hour urine specimen shows too much sugar and no reactions occur, until the dose has reached 30 units. Now, if more insulin is needed, 6 units of crystalline insulin is given as a separate injection immediately before the protamine is injected, both always being given before breakfast. Thereafter both insulins are increased by about 2 units daily for several days according to the 24 hour urine tests and blood sugar determinations-

made before breakfast to help regulate the protamine dose and before lunch for the crystalline dose. Any further increase is made so as to keep the ratio of protamine to crystalline insulin about $3\frac{1}{2}$ to 1, or say 50 units of protamine to 14 units of crystalline. Once the sugar is controlled, the insulin should be reduced by a few units, usually by visits to the office, on the basis of tests of samples of the 24 hours urine which the patient saves at home the day before his visit. I usually see the patient every 3 days and reduce the dose about 3 to 4 units whenever the test is sugar free or an insulin reaction occurs, keeping the ratio about $3\frac{1}{2}$ to 1 and bearing in mind that most patients needing only 30 units of insulin can be controlled with protamine alone.

Various conditions affect the insulin need. Infection and acidosis are two. Another is pregnancy. Dr. Priscilla White at the Joslin clinic has had a wide experience in this field. One interesting feature of her work concerns the influence of the hormones, chorionic gonadotropin and pregnanediol, on the fetal mortality. With control of these hormones she has lowered the fetal mortality rate from 40% to 10% which is comparable to that in the non-diabetic. At present we are checking this enviable record by similar tests on our cases. The gonadotropin determinations are done by assay on animals and should be run every 2 weeks or oftener in the last third of pregnancy. The use of large doses of stilbestrol and progesterone seems to restore the hormone balance and save the fetus.

In addition to this upset during pregnancy, the diabetes may vary in two ways. Occasionally, there is a lowering of the renal threshold so that glycosuria occurs even with a normal blood sugar. This is no great problem if recognized, but it leads to repeated insulin shock if not. A more serious change is a rapid and marked increase in the severity of the diabetes which seems to occur about the 7th month. At this time acidosis may arise and become severe with very little rise in the blood sugar. At such time we must discard our rule for making small and infrequent changes in the insulin. The dose may need to be increased 10 or 15 units daily. Case No. 909 had a rise in insulin requirement from 28 units to 116 units 13 days later and during that time developed marked acidosis even with this rate of increase. With prompt attention the acidosis subsided, and now both mother and fetus are well. Following delivery there is often an abrupt decrease in the severity of the diabetes so that in spite of reductions of 6 units daily blood sugar values of 50 mg. were obtained in Case No. 285. The insulin dose in Case No. 505 fell from 85 units to 26 units in the 9 days after deliver.

Insulin resistance is always disturbing. To combat it one must keep in mind the main rule in insulin therapy, "The needed dose is unknown. Prescribe as best you can and check the result to see what is needed next." In the absence of an emergency one can go somewhat slowly, but larger doses

at shorter intervals are given than in the routine case. In the presence of acidosis the danger from acidosis far exceeds the danger from insulin shock and large doses of crystalline insulin, as much as 50 units or more, should be given at half hourly or hourly intervals until the patient responds and the blood sugar falls as indicated by tests made every 3 or 4 hours. I have in the hospital now one patient, Case No. 1052, who requires 315 units of insulin daily with no discoverable relevant complication. An extreme case of insulin resistance, Case No. 908, developed during the course of diabetic coma and caused me no end of trouble last January. When first seen by me, she had a blood sugar of 1008 mg. which fell to 576 mg. in 6 hours with 585 units of regular insulin. Her CO_2 was 10 vol. % and she was delirious rather than comatose. After the initial improvement and in spite of an additional 175 units of insulin she evidently became insulin resistant and her blood sugar rose to 944 mg. The insulin dose was increased till 10 hours after I first saw her she was getting 100 units of regular

insulin every $\frac{1}{2}$ hour. This was continued for 12 hours. At this time her blood sugar was 544 mg. and she looked as though she would die. I therefore increased the insulin to 200 units every half hour and in the next 12 hours after an additional 5000 units her blood sugar was 256 mg. and she was perfectly conscious and in excellent condition. However, the patient abruptly had a convulsion, went into shock and died, apparently not in hypoglycemia as judged by the rate of blood sugar fall, failure to respond to glucose, and a subsequent very high blood sugar not explained by glucose administration. In 24 hours this patient received 7,3000 units of insulin. Such cases as these show the difficulty of formulating rules for insulin administration. However, we can certainly get rather good results if we follow the general rule that routinely the dose of insulin outside the hospital is varied only 3 to 4 units every 3 days and that in emergencies other than hypoglycemia much larger increases are made at frequent intervals and most important of all checked by frequent tests.

Immunity To Diphtheria In Student-Nurses

J. I. WARING, M.D., CHARLESTON, S. C.

Obviously the question of immunity is important for nurses who are likely to come in contact with diphtheria. It has been routine practice to do the Schick test on classes entering the nursing school at the Medical College, and to immunize all those students who showed positive reactions. Toxin-antitoxin has been abandoned in favor of alum-precipitated diphtheria toxoid, which has been given without preliminary test and without any considerable reaction afterward. Figures for the past few years are as follows:

Year	Number Tested	Number Positive
1937	32	4
1938	48	8

1939	51	9
1940	49	6
1941	59	8
1942	22	3
1943	64	8
	—	—
TOTALS	325	46 (14.15%)

The age group was 18 to 22 years, with only a few over 22 years and none over 26 years. Classes included students from all over the state, from both urban and rural districts.

Since about one in every seven nurses was susceptible to diphtheria, routine testing and immunization are worthwhile procedures.

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price

Florence, S. C.

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A PHYSICIAN'S PLEDGE

for

the New Year

At this, the beginning of a New Year, I pledge myself, with the help of the Great Physician, to devote my energies, my fortune—yea, my life, if needs be—toward the attainment and protection of those things which I hold most dear:

A baby's rosy cheeks—freedom from disease and freedom from want,

A little girl's merry laugh—freedom from fear and freedom from oppression,

A boy's questions — freedom of speech and freedom of investigation,

A woman's love—freedom of friendship and freedom to marry the choice of one's own heart,

A man's religion—freedom to worship God and to serve Him according to one's own conscience.

"KILLED IN ACTION"

A close friend of ours has just received a message from the War Department that his son has been "killed in action."

"Killed in action." We knew the boy—a tall, strapping, handsome young fellow who had entered the service of his country with a ready smile and a willingness to serve. The public schools of Florence, the Citadel, and special training in the army had made him a soldier and a man of whom any nation could be proud. The future held so much for him with his abilities, his personality, his character, and he would have been a leader in his chosen field and his community—and now he is gone.

"Killed in action." The love of a father and a mother were wrapped up in that boy. His father had served in World War One and had given his best to "make the world safe for democracy" and to "win the war to end all wars." And now his only boy is the victim of a second war. Since this lad's first cry, his mother had devoted her energies toward preparing him for adult life, for the place which he would assume in the affairs of men—and now that place will never be filled.

"Killed in action." The community in which he lived and the nation which he served had striven to afford him those advantages which make for healthy growth and development. The church, the schools, his home, his friends had all joined forces to give him the best they knew. They anticipated great things from him in the days which lie ahead—and now those days will never be lived by him amongst them.

"Killed in action." Why, we cry—in our finite wisdom—why should this young lad be the victim of men's hate and greed? What did he do that he should pay the price for the avarice and treachery of older men? Why should a young man with so much to live for be the one to go while others whose lives are well spent linger on? How can a merciful Providence allow such a thing to happen?

"Killed in action." Yes, he has gone—but not to oblivion. Somewhere "out beyond the sunset," he lives. And out there his family and his friends will be with him again some day. He lived and died that others might live—if we will but learn the lesson which his life and death have taught. The lesson that the Golden Rule and not the Rule of Greed must control the actions of men, that love and not hate must control the emotions of men, and that the Prince of Peace and not the god of war must rule the hearts of men.

"Killed in action." Yes, "but he being dead, yet speaketh." A new generation of boys and girls is on the way, he seems to say, and I gave my life to protect them today—it is your task to protect them against tomorrow. If you will do this, my life will not have been lived in vain.

ACTION BY COUNCIL

At a call meeting of the Council held in Columbia on Dec. 19, 1944, the proposed program for the expansion of the Medical College of the State of S. C. was presented in detail by Dr. T. A. Pitts, Chairman of the board of Trustees of the Medical College, and Dr. L. M. Stokes, member of the Board.

After discussion, the Council passed the following resolution, unanimously;

"Resolved, that the Council endorse in principle the Expansion Program for the Medical College, as outlined by Dr. T. A. Pitts, and that the Council offer its full support to the Board of Trustees of the Medical College in the attainment of this objective."

METHOD OF NOMINATING OFFICERS

It is profitable to see what others are doing. With this in view, we present for consideration the method used by our sister, the Medical Society of the State of North Carolina, in nominating officers for the state association.

"By-Laws — Chapter V

Section 2. The House of Delegates at its first session, shall select a Committee on Nominations, consisting of ten delegates, no two of whom shall be from the same councilor district. It shall be the duty of this committee to consult with the Fellows of the Society, and to hold one or more sessions, at which the best interests of the Society and of the profession of the State shall be carefully considered. The committee shall report the result of its deliberations to the House of Delegates in the shape of a ticket containing the names of one member for the office of President-Elect and one member for each of the other offices to be filled at the annual meeting.

Section. 4. Nothing in this article shall be construed to prevent additional nominations being made by members of the House of Delegates."

IT CURES AND IT KILLS

The sulfonamides have been a boon to mankind and have cured thousands of individuals. But the sulfonamides can also kill—as a recent happening will testify.

A small colored infant was taken to a physician's office for examination. Finding a tonsillitis and beginning otitis media in the baby, he prescribed sulfadiazene in a chocolate base—a sufficient quantity to last three or four days. The prescribed dosage was slightly less than one grain per pound per day.

Four weeks later, the infant was brought back to the physician's office with the complaint of "no strength and no appetite." One glance showed a profound anemia. (The hemoglobin was less than ten.) A transfusion was given immediately and then another—but to no avail. The infant died.

On questioning, the mother explained that the baby improved so rapidly on the medicine when it was first given that she knew it was "good for the baby," and—having the prescription refilled as necessary—continued its use for over three weeks. Full dosage of sulfadiazene for over three weeks—and the patient died.

Four mistakes were made which were responsible for this infant's death. The first two were made by the physician and were excusable. The third was made by the druggist and the fourth by the mother—and these two were inexcusable.

The physician should have told the child's mother not to have the prescription refilled—particularly since she was one who knew nothing of medicine or medical care. Secondly, he should have written "Non Rep" on the prescription, to make sure that there was no refilling of the bottle.

The druggist erred in refilling a prescription containing one of the sulfonamides without the sanction of the physician. The promiscuous sale of the sulfonamides over the counter,—and such this was—is fraught with great danger. Would that there were

some agency which could enforce existing provisions prohibiting such practices.

The final mistake was made by the mother in continuing the giving of medicine concerning which she knew nothing. Self-medication or lay-medication may be a great boon to the venders of patent medicines but it teaches a practice which may—as in this instance—lead to fatal consequences.

The moral to this story for the physician is obvious. Caution patients against having sulfonamide prescriptions refilled, and write "Non Rep" on all such prescriptions.

ALUMNI ASSOCIATION BULLETIN

Miss Annabelle W. Furman, Librarian for the Medical College has asked that we publish the following:

"It has been brought to my attention that some physicians who receive the Journal have not been receiving the Bulletin published by the Alumni Association. If anyone has not received the Bulletin, please communicate with me."

DEATHS

Dr. H. E. McDowell died suddenly at his office in Spartanburg, S. C., on October 31, 1944. A graduate of Emory University (Class of 1895), he was in active practice for fifty-three years. He was a native of Spartanburg County, and was widely known and much loved in Spartanburg where he served his community for many years.

Dr. McDowell is survived by his wife, Mrs. H. E. McDowell, the former Miss Maggie Mae Haskins, three sons, five grand-children, and two great-grand-children.

Dr. Belton Drafts Caughman, 59, died at his home in Columbia on Nov. 30th.

A graduate of the Univ. of South Carolina and of the University of Maryland School of Medicine

(1911), Dr. Caughman devoted his work in Columbia to diseases of the eye, ear, nose and throat. He served for a period in the Army in World War One. For twenty years he was attending physician, without charge, to the children of Epworth Orphanage.

Dr. Caughman is survived by his widow, the former Miss Bertie Moore.

Dr. George P. Frey, 49, died suddenly at his office in Spartanburg on November 11.

Dr. Frey was graduated from the Medical College of the State of S. C. in 1930. He served on the Staff of the State Hospital in Columbia for a period and then entered general practice in Johnsonville. Two years ago he returned to his native county of Spartanburg where he worked until the time of his death.

The Ten Point Program

M. L. MEADORS, EXECUTIVE DIRECTOR AND COUNSEL

BLUE CROSS UNDER WAY

With the meeting at the Wade Hampton Hotel in Columbia on Thursday, November 30th. of the temporary directorate of the proposed Blue Cross plan, a long step was taken toward realization of the first of the objectives which our attention has been first directed under the Ten Point Program. All but six of the twenty-five members of the group were present. Such attendance and the interest exhibited was indeed gratifying. The group consists of representatives of the medical profession, hospital trustees and administrators, businessmen, farmers and clergymen. Elsewhere on this page appears a complete list of the names and the business or professional affiliation of each.

The meeting in Columbia was featured by the address of Mr. J. E. B. Stuart, Executive Vice-President of Hospital Care Corporation, Cincinnati, Ohio, and by the full discussion of the subject, led and directed by him.

Mr. Stuart spoke from a wealth of experience in the successful operation of one of the largest Blue Cross plans now in existence. He described fully the principles of pre-payment hospital insurance under the Blue Cross plans, and those which should guide us in setting up an organization in South Carolina. The features of such plans which distinguish them from the usual contracts of commercial insurance companies were stressed, along with the essentially different methods of securing memberships and the relationships between subscribers, the organization as a unit, and the participating hospitals.

Warning signs were raised by Mr. Stuart at a number of pitfalls by which other plans have been caused serious difficulties, and we are fortunate at being in a position to profit by the experience of others, including in a large measure, the organization headed by Mr. Stuart, in working out the set-up for the plan in South Carolina.

Under the Cincinnati plan, complete coverage has been recently instituted—the subscriber is guaranteed full hospital service (excepting only certain of the most unusual types of conditions.) Mr. Stuart expressed the opinion that possibly in one or two instances they had gone too far, but on the other hand, as he pointed out, the experience from the standpoint of utilization of certain services guaranteed under the new contract, has not proved as widespread experience as was anticipated.

It was evident from his remarks that the South Carolina—and any other new-plan, should proceed gradually, on a safe, sound basis, offering limited benefits at first, both from the standpoint of type and

length of hospital service, and that these should be increased from time to time as circumstances and the condition of the reserve fund permit. Complete coverage however, should be the ultimate goal.

Mr. Stuart's complete mastery of the subject was clearly in evidence. From the beginning of his remarks he invited questions and they were not long in forthcoming. The result was a total absence of formality, and full, open discussion of any and all questions in the minds of those present. No better method could have been adopted to assure complete understanding of the principles, purpose and method of institution and operation of Blue Cross plans. There was no reasonable excuse for the departure of any member of the group without a fairly clear idea of what is in prospect.

The above being true, it is especially reassuring that practically the unanimous reaction seems to have been favorable. In fact, no unfavorable comment or criticism was heard, and the meeting was concluded in an atmosphere of complete cooperation among the several groups represented. This, needless to say, was as it should be.

The informative discussion conducted by Mr. Stuart consumed the morning session. Arrangements had been made for luncheon in one of the private dining rooms of the hotel. The first order of business, when the meeting was resumed after lunch, was the election of officers and appointment of committees for the handling of preliminary work looking toward the permanent organization. The following were chosen:

Mr. T. C. Callison, Columbia—President
Mr. J. B. Norman, Greenville—Vice-President
Mr. George A. Buchanan, Columbia—Treasurer
Mr. R. L. Moser, Columbia—Secretary

A motion was adopted that the Executive Committee consist of the President, Vice-President, Treasurer and four members elected from the directorate. Those elected to serve on the Executive Committee with the officers named were:

Mr. F. O. Bates, Charleston
Mr. R. S. Huntington, Greenville
Dr. Julian P. Price, Florence
Rev. George Lewis Smith, Aiken

At a meeting of the Executive Committee on Friday morning, December 1st, additional committees were selected as follows:

Finance: Mr. A. B. Taylor—Chairman
Legislative: Mr. George A. Buchanan—Chairman
Hospital Relations—Rev. George Lewis Smith—Chairman
Medical Relations: Dr. W. T. Brockman—Chairman
Publicity: Mr. George A. Buchanan—Chairman

Of necessity, the whole structure, from the per-

sonnel of the directorate on up, is temporary since an enabling act must be adopted by the State Legislature before the organization can have legal existence. There is every reason to believe this will be effected at the approaching session of the General Assembly, and of course, the assistance, support and activity, of many or all of those who constitute the temporary set-up is looked forward to in the permanent organization.

TEMPORARY ORGANIZATION

Believing that the information will be of interest to, and deserves the attention of all members of the South Carolina Medical Association, we present herewith a complete list of members of the proposed directorate of the temporary organization of the Blue Cross plan for South Carolina, together with their respective business or professional interests, and places of residence:

Mr. Neville Bennett, Chairman, Special Service Comm. S. C. Farm Bureau, Clio, S. C.
 Mr. R. W. Arrington, President, Union Bleachery, Greenville, S. C.
 Mr. F. O. Bates, Superintendent, Roper Hospital, Charleston, S. C.
 Dr. W. T. Brockman, Physician, Greenville, S. C.
 Mr. Geo. A. Buchanan, Editor and Publisher, Columbia Record, Columbia, S. C.
 Dr. Geo. H. Bunch, Physician, Columbia, S. C.
 Mr. T. C. Callison, Atty. at Law; Trustee S. C. Bapt. Hospital, Columbia, S. C.
 Mr. A. C. Connelley, President, J. M. Connelley Co., Charleston, S. C.
 Mr. R. L. Dougherty, Business Manager, The Orthopedic Hospital, Columbia, S. C.
 Mr. J. B. K. DeLoach, Superintendent, Columbia Hospital, Columbia, S. C.
 Dr. Dexter M. Evans, Physician, Lake City, S. C.
 Mr. L. C. Fisher, President, Fisher Lumber Co., Charleston, S. C.
 Mr. Chas. S. Gardner, Business Manager, McLeod's Infirmary, Florence, S. C.
 Mr. Geo. W. Holman, Superintendent, York County Hospital, Rock Hill, S. C.
 Mr. Roger S. Huntington, President, Huntington & Guerry, Chairman, Board of Governors, Greenville General Hospital, Greenville, S. C.
 Dr. Kenneth M. Lynch, Dean, Medical College of S. C., Charleston, S. C.
 Mr. M. L. Meadors, Executive Director and Counsel, Ten Point Program, S. C. Medical Association, Florence, S. C.
 Mr. J. B. Norman, Superintendent, Greenville General Hospital, Greenville, S. C.
 Dr. Julian P. Price, Physician, Florence, S. C.
 Rev. J. E. Rawlinson, Pastor, First Baptist Church, Orangeburg, S. C.
 Rev. Geo. Lewis Smith, Diocesan and Director, Catholic Hospitals, Charleston Diocese, Aiken, S. C.

Mr. W. W. Smoke, Editor and Publisher, Walterboro Press and Standard, Walterboro, S. C.

Mr. A. B. Taylor, President, Taylor-Colquitt Co., Spartanburg, S. C.

Rev. W. M. Whiteside, Superintendent, Baptist Hospital, Columbia, S. C.

PROGRAM INDORSED BY THE HOSPITAL ASSOCIATION

On Friday morning, December 1st, your Director was invited to discuss the Ten Point Program before the convention of the State Hospital Association, held in the ballroom of the Wade Hampton Hotel in Columbia. He followed immediately an address by Mr. J. B. Norman, Chairman of the Legislative Committee of the Hospital Association, on the Blue Cross plan. Mr. Norman has been most active in planning and in making arrangements for the preliminary organization of the Blue Cross plan.

Our remarks were devoted to full discussion of the program as a whole, each point being taken up specifically, and the matter being dealt with at length. The audience was attentive and evidenced real interest. Immediately following our remarks, Rev. W. M. Whiteside of Columbia, made a statement expressing his personal approval and desire for cooperation, and also his opinion, that the program should have the whole-hearted backing of the State Hospital Association. He expressed the view that the movement toward government control of medical practice would be followed immediately by similar control of hospitals and hospital services, that the doctors had acted wisely in taking the initiative in a positive program toward effecting the necessary changes without government control, and that they deserved full support. He made a motion that the State Hospital Association go on record as indorsing fully the Ten Point Program of the South Carolina Medical Association.

Mr. Whiteside's motion was seconded by Rev. Geo. Lewis Smith of Aiken, and by Mr. J. B. Norman, the latter emphasizing the extent of activity and value of the cooperation being received from the Medical Association in connection with the Blue Cross plan. The motion for indorsement of the program was unanimously adopted.

BLUE CROSS AND THE COMMERCIAL INSURANCE COMPANIES

Several inquiries have been received, and no doubt these will continue to arrive, as to the effect of the Blue Cross organization on the business of commercial insurance companies in the state. During recent years, many of the old line companies have recognized in hospitalization and health insurance promising fields for expansion. Many good contracts are on the market covering risks of this kind. In addition to the companies which formerly handled life insurance, principally or exclusively, and which are now operating also in other fields, a number of

smaller companies have been organized in this and other states for the purpose of specializing in health and hospital insurance. Most or many of these contracts include clauses providing for the payment of substantial sums in the event of accidental death of the policyholder. This feature however, is merely incidental to the main contract and may be compared with the double indemnity clause available with most ordinary life insurance policies.

Some concern has been evidenced by people interested in some of these insurance companies—friends and some of them members of the medical profession, and their companies sound and substantial organizations. As we see it, there is no cause for alarm or antagonism on the part of these companies, but on the contrary, there is real reason why the organization and successful operation of Blue Cross plans may well be in their interest.

Actually, the two types of business differ to such an extent that they should not be regarded as strictly competitive in the usual sense of the word. The Blue Cross plan involves certain fundamental principles which give it advantages and enable it to present an appeal to the public such as none of the commercial insurance contracts which have come to our attention have been able to achieve thus far. Especially the differences are these.

The Blue Cross plan is a non-profit organization. Its working capital does not consist of dividend-paying stock. It belongs to the members of the plan, the subscribers who pay the weekly or monthly charges for the benefits provided under the contract. The surplus accumulated, in excess of the amount necessary to repay the original working capital, is held as a reserve fund for the payment of hospital bills. When the amount of such reserve exceeds that which reasonable business judgment indicates is necessary to meet normal demands, the fund is made available, not to stockholders in the form of dividends, but to members of the plan in the way of increased benefits or reduced charges. Naturally, such a plan has greater appeal to the average citizen than one in which he realizes that a portion of his dollar paid for protection, ultimately goes to a stockholder in dividends.

The second main distinguishing feature of the Blue Cross contract is the fact that it guarantees a specific service and not simply repayment to the subscriber on an indemnity basis, in dollars and cents for the expense, or a portion of the hospital expense, he has incurred. The latter is the system generally used by the commercial insurance companies. The amount provided under the contract is paid to the policyholder, who in turn may apply it on his hospital bill.

The average subscriber to a hospitalization prepayment plan is interested, primarily, in service—the assurance that he will receive hospital care to the extent necessary and for the length of time required. That service, within limitations of the

agreement, is guaranteed by the Blue Cross contract.

A third feature which distinguishes the plan is its method of dealing directly with the hospital. Most commercial insurance companies do not. For this reason some of the hospitals do not readily admit patients simply upon the strength of their being policyholders, since there is no direct contractual relationship between the hospital and the insurance company. The opposite is true under the Blue Cross plan. There, the patient is admitted on presentation of his identification card showing him to be a member in good standing of a Blue Cross plan. The services guaranteed under his contract are provided, and the hospital mails the bill directly to the office of the Plan and receives its check. As a rule, membership in any Blue Cross plan which is duly qualified and identified by the American Hospital Association is recognized by established hospitals all over the country, so that no matter where the subscriber travels, hospital service is available in accordance with and to the extent provided under the terms of his contract.

If the proposal for federal control of medicine is carried through under the Wagner-Murray-Dingell Bill, or any other comparable legislation, it will automatically dispense with any need for voluntary hospital and health insurance. Blue Cross plans will not be able to operate, and by the same token no hospital or health insurance contracts will be sold by the commercial companies. The taxpayer, who is required to pay substantial amounts for the support of a federal system of health control, the benefits of which are available to him, will not be interested in buying commercial health insurance.

It is generally conceded that the most practical way to discourage the development of federal control of medicine, is to achieve the necessary reforms or improvements in some other way and that voluntary insurance under the hospital and medical service plans offers the surest and most practical method of doing that. This being true, it appears that widespread use of the Blue Cross plan will do more than anything else to maintain the opportunity now available to the commercial companies to offer their contracts for hospital insurance on a free and open market.

FIRST DISTRICT MEETING

A meeting of the First District Medical Society was held at Walterboro, at six o'clock on the afternoon of December 7th. Despite inclement weather, the attendance was splendid and included doctors from nearly all, if not every one of the counties in the district, with a substantial representation from the city of Charleston.

The meeting was held in the dining room of the Interstate Glass House, where, following the business and scientific session, a delicious dinner was served.

Following the election of officers and transaction

of routine business, interesting scientific papers were read by Dr. B. O. Ravenel and Dr. Paul Sanders. Dr. Kenneth Lynch then discussed the plans for expansion of the Medical College, and this was followed by full discussion of the Ten Point Program by your Secretary and Director. The latter dealt specifically with the Blue Cross plan, and the steps being taken toward organization in South Carolina, while Dr. Price talked on the subject generally. Interest of those present was evident and

the reaction favorable. Printed copies of the program were distributed and a request has since been received from one of the doctors in the First District for a large number of these for distribution among his patients. Incidentally, we are in position to supply any number of similar requests.

Plans are now under way for similar discussion of the program at a meeting of the Fifth District Society, at Winnsboro, on January 18th.

NEWS ITEMS

Dr. Rowland F. Zeigler of Seneca recently gave a radio talk over WFBC in Greenville on the possibilities of alien diseases in the United States.

Capt. Allen C. Bradham, formerly of Anderson, has been assigned to the 236th General Hospital Unit (Camp Barkeley, Texas) as Chief of Urology.

Announcement was made by the American College of Surgeons that the following physicians from S. C. had been received into fellowship in the College in 1944; Drs. George R. Dawson of Florence, Paul P. Hearn of Greenville, and John M. Settle of Charleston.

South Carolina was represented at the meeting of the Southern Chapter of the American College of Chest Physicians held in St. Louis, Nov. 13 and 14, by Drs. R. K. Brown of Greenville and Wm. H. Moncrief of State Park.

Capt. W. H. Powe, formerly of Greenville, has sustained an injury to his arm from the fragment of a high explosive shell.

Lt. Col. Everett Poole, formerly of Greenville, is now Executive Officer at Camp Van Dorn, Miss.

Capt. Thomas Chisholm (U. S. P. H. Service) has been appointed as acting director of Venereal Disease Control of the State Board of Health. He was graduated from Erskine and from the Medical Department of the Univ. of Tenn.

Dr. Ben F. Wyman, State Health Officer, was elected Secretary of the Section on Public Health of the Southern Medical Association.

In a recent letter relative to the Ten Point Program, Dr. W. Tertsy Lander of Williamston enclosed the following interesting account of his recent illness;

"Six months ago I had an attack of Coronary Occlusion. Fortunately, I was incidentally at the Anderson Hospital and received prompt attention from Dr. Wrenn and two of the Dr. Youngs. The excruciating pain was soon relieved. I was put on the accepted treatment of heart tonics and complete rest. When I was permitted to read, I reviewed the pathology as given by the best authorities in reach, and carefully considered the findings of my own case. I am led to consider the episode as an accident to the heart rather than a disease of it. The disease in my case (likely in others) seemed to be lack of calcium. With a satisfactory calcium level established, all intimation of heart trouble disappeared. Increasing exercise showed the heart in safe

condition. This may be judged from the fact that, for a month, I have done any labor at hand. A dozen times for half-an hour I have used the black smith sledge. In five minutes pulse returns to 72, no shortness of breath, no heart consciousness, apex beat at right place. I am still — and evermore — scrupulous about the calcium."

A colleague gave us the following letter which he had recently received from the wife of a former patient;

"hello Dr,

I will rite you a letter to fine out what the matther you have seen my insurance pappy I been look for them to been Back a long time and i havent got them yet so I wish you seen them on i close hope to hear from you soon
from _____"

OLIN CHAMBERLAIN WORKS WITH DISNEY ON MEDICAL FILMS

Lieutenant Colonel Olin B. Chamberlain, army medical corps, of 48 South Battery, and Walt Disney, motion picture cartoonist, are cooperating with officers of the army signal corps in making medical educational films, at the Metro-Goldwyn-Mayer studio, at Hollywood, word has been received in Charleston.

Colonel Chamberlain, who was a practicing physician in Charleston before his entrance into the service in June, 1942, has been serving as head of the army's largest neuropsychiatry department, at Bushnell General hospital, Brigham City, Utah. He is now on an assignment of about 60 days, at Hollywood, to act as technical medical adviser for the filming of the pictures.

The films will show characteristics and treatment, chiefly by means of baths, of neurotic patients. They are intended for the instruction of army medical officers, nurses and attendants and probably will not be shown to the general public.

Disney's work in these films will not resemble the comic cartoons for which is known, except that it will consist of animated pictures. His aid was asked because it will be easier to show gaits and facial expressions characteristic of neurotic patients by animated pictures than by using actors. Pictures of real patients could not be used, because this would violate their privacy.

MEDICAL SUMMARIES

B. O. RAVENEL, M.D., CHARLESTON, S. C.

PNEUMONIA IN CHILDREN

At this season of the year, pneumonia is by far the most frequent serious illness encountered in infants and children and the sooner it is diagnosed and treatment instituted, the better the prognosis.

We believe it advisable to place all types of pneumonia under two general heads:

(1) Primary Pneumonias and (2) Secondary Pneumonias.

Under the heading of primary pneumonias we can subdivide them into three groups—(a) Lobar (b) Lobular, and (c) Primary atypical pneumonia, (which will not be discussed in this paper), while we consider a secondary pneumonia under the term of bronchopneumonia.

The primary pneumonias are thought of as those which come on usually without any known predisposing cause while bronchopneumonias are secondary to some disease of the respiratory tract as measles, influenza, pertussis, scarlet fever, etc., or to some mechanical or chemical agent as kerosene which is aspirated.

Lobar pneumonia is due in practically all cases to the pneumococcus. This process is usually limited to one lobe of the lung which may become completely or partially consolidated.

In the lobular type of pneumonia which is most usually due to streptococci but may be caused by pneumococci, staphylococci or influenza bacilli, the organisms also reach the alveoli by way of the lymphatics of the interstitial tissue. Gaskell has shown experimentally that if the organisms are of low virulence, a patchy pneumonia will result. At times this lobular distribution becomes confluent and it is difficult to determine whether the patient actually has a lobar or lobular pneumonia.

In bronchopneumonia, which according to our classification is always a secondary pneumonia, we have a definite predisposing factor which sets the stage. (i. e. an attack of measles, pertussis, scarlet fever or influenza, some chronic wasting disease, or aspiration of some foreign material). In this type, the influenza bacillus is probably the most frequent invader, but the pneumococcus, streptococcus or staphylococcus may be the causative organism. Here the process proceeds by direct extension into the alveoli rather than by the lymphatic route. The bronchi and bronchioles are damaged by the primary disease and desquamated epithelium and mucous cause blockage of many small areas with resultant scattered areas of atelectasis which in turn become infected.

In pneumonia in infants, we find frequently that

(Read before the First District Association, Walterboro, Dec. 21, 1944.)

the patient had been in good health and that he was suddenly taken ill, or in a large number of cases the child has a history of having had a mild upper respiratory infection for two or three days and the parents noted that he seemed to have taken much worse in a period of a few hours. The acute onset with a chill is usually not found in a small child as is seen so commonly in older children and adults. Not infrequently the little patient has one or more convulsions. He appears dull and apathetic, is quite content to lie quietly in bed, develops anorexia and within a short time, the child appears quite ill. It is about this time, if convulsions have not appeared earlier, that the doctor is usually called in. On arrival at the bedside, he finds an acutely and seriously ill child who has a rapid respiration, not infrequently with an associated expiratory grunt. The child is lethargic, has an apprehensive look on his face, and may or may not resent the physical examination. The temperature is found to be 102° to 104° (F). The skin is hot and dry and the pulse, rapid and full. Examination of the abdomen may reveal no abnormal findings or there may be a moderate amount of distension. Not infrequently, one finds one side or the other somewhat tender with definite muscle guarding. This is probably due to diaphragmatic pleurisy which may be found on examination of the chest. This sign is very frequently helpful in determining which lung is involved.

Careful inspection of the chest occasionally affords information. If there is pleural involvement, definite splinting of the involved side may be seen and in many cases one finds lessened expansion on the side where the pathology is present. It is through auscultation that we find the earliest signs of pneumonia—a suppression of the breath sounds over the affected lobe. There may be a few, fine crepitant rales at the end of inspiration, but these are not the rule in early cases. As the process continues, the signs of consolidation become apparent and there is no difficulty in making the diagnosis. At times, it is advantageous to make an infant cry to bring out the signs of consolidation which cannot be heard when he is quiet.

On percussion in the early stages, there are no changes elicited, even though there is definite suppression of breath sounds, but as the time goes on, there is first impaired resonance over the affected side, when compared to the normal side, the dullness to flatness may appear.

In lobular and bronchopneumonia, the physical signs in the chest are indistinguishable and the only way we can differentiate these is by the clinical history, the former giving a history which reveals that the process is primary while in the latter, the history is

of a previous infection which has set the stage for a secondary pneumonia. On auscultation in these cases, we find the lungs literally full of coarse and medium rales as are found in bronchitis but on further search, we find one or more areas on one or both sides where there are showers of fine inspiratory rales which are distinctly different from those heard throughout the rest of the chest. There may or may not be a faint suggestion of bronchial breathing in these areas, and there is no change in the percussion note. As the process continues, we are able to find definite patchy areas of consolidation and at times these areas become confluent to give the impression that there is lobar involvement rather than lobular or bronchial.

Since the advent of the sulfonamides, the treatment of the various type of bacterial pneumonias has been simplified and standardized to some extent. In the Pediatric Department of Roper Hospital, the routine orders on all patients admitted on the service with the diagnosis of pneumonia include a blood count and urinalysis; sputum for typing of pneumococci; a blood culture; X-ray of chest and either sulfathiazole or sulfadiazene which is administered in doses of 1 grain per pound body weight per day divided into 6 doses. In order to try to prevent crystallization of the drug in the kidneys, alkalization of the urine is attempted by giving an equal quantity of sodium bicarbonate with each dose of which ever drug is used. For the pneumonia patient who is moderately ill this dosage schedule has proven to be quite satisfactory. However, if the patient appears to be seriously ill the initial dose of the sulfonamide should be given in a larger dose (i. e. one half of the calculated daily dose). If the child is vomiting or it is thought that it would be to the patient's advantage because of his critical condition, the sodium salt of the drug is given intravenously in a 5% solution.

Certain cases of pneumonia do not respond to chemotherapy with the sulfonamides and if no clinical response is seen after 24 to 36 hours of treatment it is advisable to institute therapy with penicillin. This is given in an initial dose of 20,000 units intravenously and then 10,000 units every three hours subcutaneously. The subcutaneous route is used in preference to the intramuscular route because absorption of the drug is slower and a more constant blood concentration is maintained. Penicillin is also used in those cases where a loud friction rub is heard and there is a chance that empyema may develop. If the patient appears to be in such poor condition that it seems only fair that he should have every type of treatment, penicillin is given in conjunction with the sulfonamides from the start.

During the time the sulfonamides are being administered, blood concentrations are obtained twice weekly and hemoglobin, leucocyte and differential counts are obtained when thought advisable. The urinary output is followed closely and frequent urinalyses are done with special attention being paid

to the presence of red blood cells and sulfonamide crystals. We have found that in the great majority of patients, the sulfonamide or penicillin can be discontinued after forty-eight hours of normal temperature. The use of serum has practically been discontinued since the discovery of the sulfonamides and penicillin.

In addition to chemotherapy, there are several other important factors that must be considered in the treatment; namely, rest, fluid balance, diet, elimination, oxygen therapy, and other drugs which may be indicated for the comfort of the patient.

As in any disease, whether acute or chronic, rest is of prime importance. The patient should be placed in bed and not disturbed more than is absolutely necessary.

The fluid balance and diet may be considered together. Pneumonia in most cases is a disease of fairly short duration and being so, it is not necessary worry much about the amount of food that the child takes during the illness. He should be offered food he is accustomed to and likes, but under no circumstances should he be forced to take the food. As he recovers he will gradually take his diet better and by the time he recovers fully, he may have a much better appetite than he had before he was taken sick. The matter of fluids should be considered from a different angle. Due to the high fever which accompanies pneumonia, there is a greater loss of fluids than is lost under normal conditions. In addition, the patient usually vomits some especially at the onset of the disease, thereby losing more fluid and not infrequently there is diarrhea associated with the disease. Taking these facts into consideration, one can see that it is necessary to get an additional amount of fluids into these patients for if their fluid balance is not maintained, they will not respond as quickly or satisfactorily to therapy. If the patient is not vomiting, it is usually possible to get enough fluids into the child orally to maintain the fluid balance. The type of fluid makes little difference and it is easier to get the child to take fluids that he likes best whether it be water, fruit juice, soft drinks, or milk. The infant will usually take sweetened fluids better than plain and adding sugar to water increases the amount of carbohydrates which are needed to carry on the metabolic processes. A good nurse or mother can get a surprising amount of fluid into an ill patient without fighting the child. Frequent small amounts of fluids add to a large total in 24 hours. If the patient, when first seen, is showing signs of dehydration or if at any time it appears that we are unable to get sufficient fluids into the child, it is imperative that parenteral fluids be given. We have found that for intravenous use a 2.5% solution of glucose in $\frac{1}{2}$ Normal Saline to be very satisfactory. This solution is entirely physiological and will not dehydrate the patient as the hypertonic 5% glucose in normal saline which is usually used, theoretically will. This solution furnishes both carbohydrates and electrolytes which are needed. For

subcutaneous use we have found the lactose ringer solution devised by Dr. Hartmann to be entirely satisfactory.

Elimination of the intestinal contents daily is desirable for the comfort of the patient and we have found that a small enema produces the desired results. A mild laxative is certainly not contraindicated but purging definitely is.

Oxygen therapy has a definite place in the treatment of pneumonia and should be used if cyanosis is present and especially if the patient is quite restless. We have found that it can be administered satisfactorily through a nasal catheter passed into the pharynx. The catheter should be changed from one nostril to the other daily and care should be taken that it is not introduced too far into the pharynx for on one or two occasions we have found the stomach distended from oxygen which was supposed to be being inhaled by the patient. In determining when oxygen therapy should be stopped it is best to cut off the supply from time to time and to observe the reactions of the patient.

For abdominal distention, which since the advent of the sulfonamides is not seen nearly as frequently, a small enema is of a great deal of aid. Another procedure which aids a great deal at times is the insertion of a rectal tube and then giving $\frac{1}{2}$ c. c. of 1:4000 Prostigmin solution subcutaneously. On several occasions we have had a patient on whom both of these procedures have failed and have passed a small catheter into the stomach with the release of a large amount of gas and immediate relief from the distention.

In some cases of lobular and bronchopneumonia where the chest is filled with rales which seem to be extremely dry and the little patient has a dry cough and is quite dyspneic and frequently cyanotic, in addition to oxygen it is advisable to place the child in a croup tent. We have found that plain steam does just as much good as adding tincture

of Benzoin or other medications to the water and this does away with the danger of suffocation by fumes of the medication, should the water boil out. The main thing is to increase the moisture in the air.

There are at least two drugs other than the sulfonamides which should be remembered in treating a patient with pneumonia. The first of these is codeine which is very useful in the control of pleural pain and the second is aspirin which in cases of hyperpyrexia (105° F. or higher) in the dosage of 2 grains per year is of value in reducing the fever. Tepid water or alcohol sponges when used in a proper manner may also be of value in this condition. For sedation, where there is restlessness or convulsions, phenobarbital or sodium amytal may be used.

The treatment of the most common complications should be mentioned in closing. The most common complication of pneumonia is otitis media. This condition is usually cared for adequately by the specific therapy of the pneumonia. In addition to this, non oily nose drops may be of some value in maintaining the patency of the eustachian tubes. In very few cases do we find it necessary to incise the drums. Next in line is empyema. Early in these cases the sulfonamides are of some value but after a case of empyema is well established they should be discontinued because as in the presence of other abscesses, there is an inhibiting action. We have treated two cases of empema very successfully with penicillin in the last three months. The cavity was aspirated daily and penicillin then injected directly into the cavity. Surgical treatment should still be used when indicated. In addition to penicillin on one of the cases we are using herapin placed directly into the thorax in an effort to cut down the formation of adhesions and fibrin clots.

Pericarditis is occasionally seen and here again penicillin directly into the pericardial sac is probably the treatment of choice.

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PUBLIC HEALTH NEWS

55 FEWER MATERNAL DEATHS THIS YEAR

The annual report of the Division of Maternal and Child Health shows 55 fewer maternal deaths in South Carolina in the past fiscal year than in 1943. Maternal deaths in 1943 numbered 256 as against 201 in 1944. Encouragingly, Dr. Hilla Sheriff, Director of the Division of Maternal and Child Health, declares that "more" expectant mothers in South Carolina are following clinical advice to engage an attendant at delivery." Dr. Sheriff also points out that "since medical care under the EMIC program is provided for the infant up to one year of age, it is logical to assume that mothers will take advantage of such care, thereby reducing infant morbidity and mortality rates in South Carolina."

ANNUAL MEETING SCPHA HELD TUESDAY, DECEMBER 5, IN COLUMBIA

The South Carolina Public Health Association held its annual meeting in Columbia, Tuesday, December 5, with more than 300 public health workers, representing practically every health agency in the State, present.

The meeting held in Drayton Hall, was presided over by the Association's president, Dr. G. S. T. Peeples. The invocation was delivered by the Rev. Samuel C. Cooper, pastor of the First Christian Church, Columbia, and was followed by an address of welcome by the Honorable Olin D. Johnston, Governor of South Carolina. Other speakers included Dr. Ben F. Wyman, State Health Officer; Dr. G. S. T. Peeples; Dr. J. R. Heller, Medical Director of the Venereal Disease Division of the USPHS; Dr. E. J. Gillespie, representing the director of the USPHS tuberculosis program; Mr. Terry C. Foster, Regional Director of the Vocational Rehabilitation Program; Miss Lucia Murchison, Medical Social Consultant of the State Board of Health; and Mr. J. M. Jarrett, Chief Sanitary Engineer of the North Carolina State Board of Health.

Dr. Wyman discussed the need for more modern equipment in the Bureau of Vital Statistics; the business organization of the State Board of Health; the new tuberculosis program; and the fact that the Quarantine Hospitals are a part of the Division of Venereal Disease. Dr. Wyman also assured the personnel of the county health departments that he was aware of their need of more money and congratulated them on what they had been able to accomplish with limited funds. Dr. Peeples spoke on Undulant Fever, stressing the importance of pasteurization of milk in the control of the disease and urging the enactment of a State or National law requiring pasteurization of all milk sold for public consumption. Dr. Heller discussed the Venereal Disease Problem in Wartime. Dr. Heller quoted statistics to the effect that of the men in the Army and Navy infected with venereal disease, 80 per cent of the infections come from promiscuous girls and only 20 per cent from commercial prostitutes. He said: "It is axiomatic that venereal diseases increase during wartime." Dr. Gillespie outlined the new tuberculosis program as it will be carried on by participating State Health Departments. Mr. Foster explained in detail the medical phases of the Vocational Rehabilitation Program. Miss Murchison gave an interesting talk on the Working Relationship Between the Medical Social Worker and the Public Health Nurse. Mr. Jarrett spoke on the Importance of Sanitation in a Modern Public Health Program. A motion picture titled *Modern Nutrition* was shown during the afternoon through the courtesy of E. R. Squibb & Sons.

The following officers were elected for the ensuing year: President elect, Dr. M. J. Boggs; First Vice-President, Dr. T. K. Fairey; Second Vice-President, Miss Catherine Ransey; Secretary-Treasurer, Mrs. Frank George; Councilors: Dr. L. A. Nimmons, Dr. J. L. Bryson, Mr. Max Turteltaub, Miss Ruby Wallace and Mr. C. C. Moore. Dr. Ben F. Wyman was elected to represent the SCPHA at the American Public Health Association.

SOUTH CAROLINIANA

COSGROVE, S. A. and CARTER, PATRICIA A. (Jersey City, N. J. and Charleston): A consideration of therapeutic abortion. (*Am. J. Obst. & Gyn.* 48:299-314, Sept., 1944)

A moral and ethical consideration of the subject. The authors believe that the fetus is a human individual and that its destruction is murder. The medical code needs more definition.

DAWSON, G. R., Jr. (Florence): A motor driven screw-holder—screw-driver. (*South. Med. J.* 37:587-588, Oct., 1944)

A super gadget for the orthopedic mechanic.

HUNT, S. P. (Denmark): A concept of hysteria. (*South. Med. & Surg.* 106:370-373, Oct., 1944)

The author believes that hysteria is a definite entity—a neurotic personality disturbance. An instance is cited at length. Psychotherapy is indicated.

JOSEY, A. I. (Columbia): Penicillin treatment of a case of tularemia without effect. (*J. A. M. A.* 126:496-497, Oct. 21, 1944)

Neither penicillin nor sulfadiazine seems to hit the tularemic spot.

LASSEK, A. M. (Charleston): The role of the New York state medical schools in the national distribution of physicians. Distributional studies. II. (*J. A. Am. Med. Colleges* 19:352-358, Nov., 1944)

Further studies by Dr. Lassek on the question of distribution of graduates of medical schools. With the present interest in increasing the size of our (South Carolina) medical school, these data are of current concern.

LAUB, G. R. (Columbia): Acute pharyngitis due to decompensation of the circulatory system. (*South. Med. J.* 37:627-628, Nov., 1944)

Very early stages of unsuspected decompensation may be recognized by cyanosis and venous congestion in the pharyngeal mucosa. Cases are cited.

IBID: Septal abscess (Case report). (*South. Med. & Surg.* 106:374, Oct., 1944)

A rare complication of influenza, treated by drainage. Illustrated.

LOWMAN, E. W., Lt. Com. USN (MC): Planned convalescence. (*U. S. Naval Med. Bull.* 43:611-620, Oct., 1944)

A discussion of the utilization of a patient's idle time in planned physical and mental pursuits with a more speedy and profitable return to health as an objective.

MAGUIRE, D. L., Jr. (Charleston): Penetrating wounds of the heart. (*South. Med. & Surg.* 106:411-415, Nov., 1944)

The mortality of this condition has decreased with improvement in surgical methods. Cardiac tamponade is the more serious feature and is indicated by circulatory collapse. Technique of repair is described and 2 cases treated successfully are reported.

PRATT-THOMAS, H. R. (Charleston): Aneu-

rysm of the abdominal aorta with rupture into duodenum. (*Am. J. Clin. Path.* 14:405-412, July, 1944)

Report of 3 cases with details of clinical and pathological information on a rather rarely reported condition.

REMINGTON, R. E. (Charleston): The enigma of pellagra. (*South. Med. J.* 37:605-614, Nov., 1944)

The author proposes that some undetermined factor, rather than remedial measures, has caused the drop in incidence. Relief measures seem to have had no bearing. Various interesting hypotheses are offered.

SEIBELS, R. E. (Columbia): Effectiveness of a simple contraceptive method. (*Human Fertility* 9:43-47, June, 1944)

The use of syringe and jelly or creme is acceptable to 85% of rural patients and is more than 90% effective.

TAFT, R. B. (Charleston): Radium contamination of roentgen films. (*Am. J. Roent. & Radium Therapy* 52:445-448, Oct., 1944)

This seems to result from the presence of small quantities of radium salts in cardboard film boxes. Tissues used to clean brushes used in painting luminous dials are discarded as waste paper which subsequently becomes cardboard.

WALTON, R. P. (Charleston): "Essentials of Pharmacology," by M. K. Geiling and others in collaboration with R. P. Walton. Chi., Univ. Chicago Bookstore, 1944, 166p.

A schematic outline intended for pharmacology teaching.

IBID: Ultimos adelantos en quimioterapia. Un comentario de los progresos fundamentales durante 1943. (*Rev. Argentino-Norteamericana de ciencias med.* 1:782-787, Jan., 1944)

A review of recent developments in drug therapy. Topics discussed are penicillin production, dose schedules and toxicity; the sulfonamides: sulfadiazine, sulfamerazine, sulfamethazine, sulfapyrazine and sulfacetimide; intensive treatment schedules of early syphilis and the drugs mapharsen, chlorarsen or phenarsine; air sterilization with vaporized glycols; heparin and dicoumarin; plasma and blood albumin fractions; the newer morphine substitute demerol (dolantin, pethidine).

ZIMMERMAN, S. L. and BARNETT, R. N. (Columbia): A case of probable meningococcus endocarditis apparently cured with penicillin. (*South. Med. J.* 37:694-696, Dec., 1944)

A case of probable subacute bacterial endocarditis, due to a meningococcus, Group I, sulfadiazine-resistant and treated satisfactorily with penicillin is reported.

The continuous intravenous drip method was used and one million units of penicillin were given over

a ten-day period, with no untoward effect.

The difficulties in differential diagnosis between

endocarditis due to a meningococcus and meningococcemia are discussed, and some differential points are suggested.

MEDICAL SOCIETY NEWS

CHESTER COUNTY SOCIETY

The Chester County Medical Society held its regular monthly meeting at the home of Dr. W. R. Wallace Friday night, December 8th. Mrs. Wallace "outdid" herself in serving a delicious turkey supper with all the trimmings. Mrs. Abe Hellman, Mrs. Phelps Brooks, and Mrs. Etta Latimer served. The tables were decorated with beautiful chrysanthemums. Dr. J. N. Gaston, Jr., presided. Dr. Wallace had the following doctors as his guests:

Dr. Tom E. Brockman of Greenville, President elect of the South Carolina Medical Association, chairman of the Woman's Auxiliary Advisory Committee.

Dr. Julian Price of Florence, secretary and editor of the South Carolina Medical Journal.

Dr. George Bunch of Columbia, chairman of Committee on Medical Education.

Dr. C. S. McCants of Winnsboro.

Dr. N. B. Heyward of Columbia, chairman of Committee on Legislation and Public Policy.

Dr. Strother Pope of Columbia, chairman of Committee on Postgraduate Medical Activities.

Dr. George Dawson of Florence, member of Committee on Postwar Planning.

Dr. V. P. Patterson of Chester, president of the State Hospital Association.

Dr. D. L. Smith of Spartanburg, member of Committee on Historical Medicine.

Dr. R. M. Pollitzer of Greenville, chairman of Committee on Public Health and Instruction.

Each of these doctors made a short report of the work done by his committee. Dr. Brockman told of his trip to the recent meeting of the American Medical Association at Chicago. The doctors discussed the "Blue Cross Hospital Plan," and the "Medical Service Plan," and the new "Ten Point Program for South Carolina."

Other local and county doctors present were:

Dr. R. E. Abell

Dr. J. B. Floyd of Great Falls

Dr. J. H. Gaston, Sr. of Edgemoor

Dr. W. J. Henry

Dr. G. A. Hennies

Dr. A. M. Wylie

Dr. R. D. Hicks

Dr. J. P. Young

FIRST DISTRICT MEDICAL ASSOCIATION

With the largest crowd in attendance in recent years, the First District Medical Association held its annual meeting in Walterboro on Dec. 7.

Following a social hour, the group enjoyed a scientific session which consisted of a discussion on Pneumonia in Children by Dr. B. O. Ravenel of Charleston, a paper on Penicillin in Genitourinary diseases by Dr. Paul Sanders of Charleston, a presentation of the Medical College Expansion Program by Dr. Kenneth Lynch, Dean of the Medical College, and a joint discussion of the Ten Point Program by Mr. M. L. Meadors, Executive Director, and Dr. Julian Price, Secretary-Editor of the S. C. Medical Association.

PEE DEE MEDICAL ASSOCIATION

The ninety-sixth annual meeting of the Pee Dee Medical Association was held in Florence on Dec. 14 with Dr. D. C. Griggs of Pageland, President, in the chair. An unusually large number attended the meeting.

The scientific session consisted of a Clinico-pathological Conference by Drs. Elias Faison and Paul Kimmelstiel of Charlotte, a discussion of the Ten Point Program by Mr. M. L. Meadors, Executive Director, a paper on Experimental Comparison of Certain Skin Sterilizing Agents by Dr. T. C. Bost of Charlotte, and a talk on The Expanding Field of Preventive Medicine by Dr. J. Alam Hayne of Columbia.

Officers elected for the coming year were: Dr. F. L. Carpenter, Latta, President, Dr. C. A. Kinney, Florence, Secretary-Treasurer.

COLUMBIA MEDICAL SOCIETY

Dr. L. Emmett Madden of Columbia was elected President of the Columbia Medical Society for 1945. Dr. J. F. Woods was elected Vice-president, Dr. Chapman Milling, Secretary, and Dr. W. A. Hart, Treasurer.

Drs. Hugh Wyman, Lewis Pitts, and John E. Holler were elected as delegates to the House of Delegates.

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AERO SAKOS

This business of beginning the New Year with a column reminds us of the WAC who was asked how she liked the Army. She said it wasn't so bad although she spent her days saying "Yes, Sir," and her evenings saying "No, Sir!" Her predicament was no worse than that of the Negro Minister.

It seems that this minister was "caught" kissing one of his choir girls. When he was questioned by the members of the Board of Deacons, he explained his action away by reminding them that as their minister, he was also their Shepherd. And as the minister put it, "Your Shepherd has the privilege of taking his Lambs to his bosom!" That explanation eased the situation a bit but the members decided that they would draw up a resolution covering this case. This was done and read as follows: Whereas Brother Jones has been our minister for the past twenty-five years and

Whereas Brother Jones has convinced us that he

is our Shepherd and we are his lambs,

Be it resolved that Brother Jones may take his lambs to his bosom, but from now on they gotta be RAM lambs.

This ram story only bears out Strother Pope's dictum: Many a ram has run over a mountain side because he didn't see the ewe turn.

The war has certainly invaded our entire social structure as witness the occurrence in our Corner Drug store. A child went into the drug store and asked for a dime worth of Asafetida. When the Druggist handed her the package, the child said, "Please charge this to my father." The druggist asked, "What is his name?" The child replied, "Thistleboggan." This was too much for the druggist who said, "Take it for nothing, I'm not going to spell asafetida and Thistleboggan for a dime!"

The editor of this column wishes all his readers A Very Prosperous and Happy New Year.

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BOOK REVIEWS

A TEXTBOOK OF PATHOLOGY

By Robert A. Moore
W. B. Saunders and Company, 1944

The first edition of this book enters a held replete with excellent textbooks, yet it will find a definite place of its own. Minor faults inherent in first editions will undoubtedly be corrected in later ones.

The work is complete and includes certain uncommon conditions not ordinarily included. The discussion of diseases from the standpoint of clinicopathological correlation adds much to the value of the work.

Especially to be commended are the chapters dealing with the cardiovascular system, trauma and vitamins.

In general, the 1291 pages of this book are filled with interesting informative material which is of more value to the general practitioner and specialists than the usual basic science textbook.

W. A. C.

FEMALE ENDOCRINOLOGY

By Jacob Hoffman, A.B., M.D.
W. B. Saunders & Company, Philadelphia, 1944

The vastness of the subject of Endocrinology makes it very difficult to compile into one volume the satisfactory appreciation of the various conditions and medications associated. This particular book is very minute in its handling of symptomology

and pathology. The accepted treatments are handled in such a way as to give a variety of opinion as to possibilities. It is also a cross-section of a majority of the literature, and while not a necessary entity for the general practitioner, it is a definitely valuable reference for any medical individual.

The emphasis placed on the injudicious use of hormones is especially worthy of note, and a careful method of diagnosis is outlined for the majority of complications.

The volume is not intended to be a compend and should not be considered such in any respect.

A. L. R.

MANUAL OF MILITARY NEUROPSYCHIATRY

Harry C. Solomon and Paul I. Yakovlev
W. B. Saunders Company

This is a fat little volume which is none the less stream-lined. The list of contributors is impressive but of necessity each of the forty-nine topics has the limitations of a compend and only some of the merits of the AMA Yearbook. The index is good and the scattered bibliographies useful. Much of the experience with neuropsychiatric problems of Selective Service, military training, and combat duty is suggested rather than evaluated, probably because new problems are still emerging. The book can be valuable to the practitioner by increasing his understanding of the neuropsychiatric problems of a soldier after his discharge from the Army.

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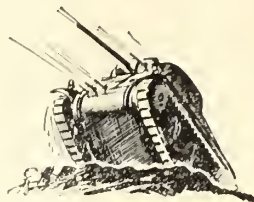
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FEBRUARY, 1945

VOL. XLI, NO. 2

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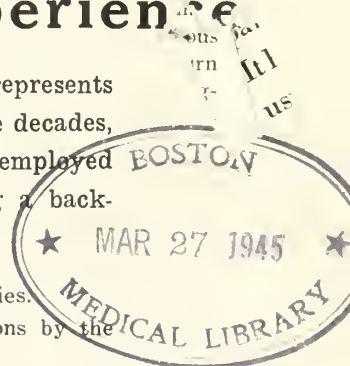
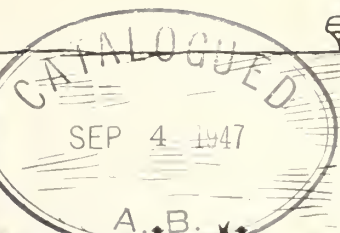
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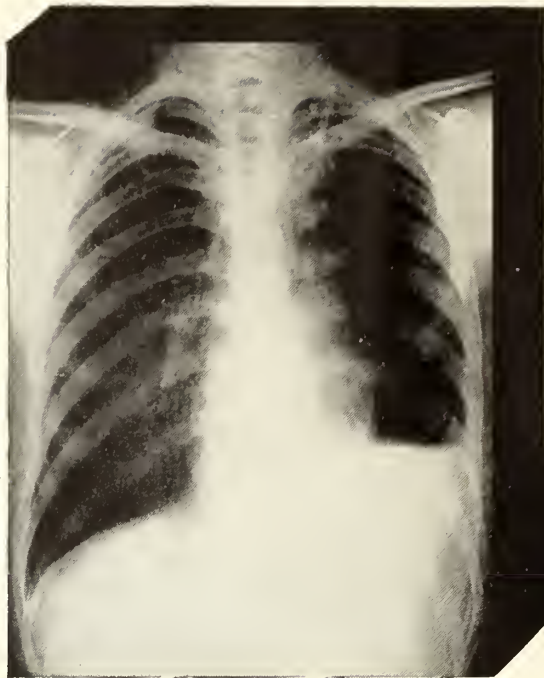
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Treatment of Burns

HENRY N. HARKINS, M.D., PH.D.

Associate Professor of Surgery, Johns Hopkins University Medical School, Baltimore, Maryland

Burn treatment has been greatly advanced by renewed interest in the subject caused by the present war. There is probably less disagreement concerning and more standardization of burn therapy than there has been for six years, since 1938, when the then prevalent tannic acid method was first questioned. With the present clarification of the subject, it is time to take stock. For this purpose, the following division of burn treatment under five headings serves as an outline for standard methods and unsettled questions:

Outline of Burn Therapy

- I. Local Treatment of Fresh Burns.
- II. Early General Treatment of Burn Shock (0-48 hours.)
- III. Late General Treatment of Burn Sepsis, Toxemia, Anemia and Hypoproteinemia. (After 48 hours.)
- IV. Early Plastic Treatment of Granulating Areas.
- V. Late Plastic Treatment of Scars and Contractures.

It is important to point out before discussing each of these phases of burn treatment in detail that the first four of them form a unit. The local and general care and early plastic care should be performed concurrently and conjointly. One of these is not complete without the others and they should preferably be performed by the same surgeon. Delays between these phases are dangerous and it is an unfortunate event to end up with a well dressed burn but a dead patient. Similarly early local care and general care without prompt grafting of granulating surfaces is like doing a cholecystectomy and then forgetting to close the abdominal wound. On the other hand, the late plastic alteration of scars and deformities had best be delayed several months until infection is out of all the lymphatic spaces. This late phase of burn treatment listed as "V" above can wisely be performed by another surgeon.

(Paper given before the Annual Refresher Course, Medical College of the State of South Carolina, Charleston, South Carolina, November 1, 1944.)

Thus, in military surgery, the first four elements of burn treatment listed above should usually be done near the scene of the accident, while for the late plastic care the patient can be brought back to this country.

Consideration will now be given to certain aspects of the five phases of burn treatment.

I. Local Treatment of Fresh Burns

The use of tannic acid in burn treatment was popular from its introduction in 1925 until 1938, when its safety began to be questioned. The whole subject of the toxicity of tannic acid has been reviewed by McClure, Lam and Romence (1944) in an article entitled "Tannic Acid and the Treatment of Burns: An Obsequy." In this article these authors point out the high incidence of liver necrosis in burn patients treated with tannic acid. Non-fatal cases frequently show a marked disturbance of liver function in the acute stage of the burn. The liver lesion is easily reproduced experimentally. Furthermore, wound healing experiments on animals and on human donor sites indicate that tannic acid retards healing considerably. The disastrous action of tannic acid as far as the healing of burn wounds is concerned has also been noted by Dingwall and Andrus (1944) and others. Now that tannic acid is no longer used, three other methods of burn treatment deserve mention at this time. Of these the first, or pressure dressings, is the most popular at the present time. The second, or plaster casts, is a modification of the pressure dressings, technic, and utilizes the same principle, while the third, or Bunyan bag, is chiefly chosen in Great Britain.

A. Pressure Dressings. When the burn is first seen it should be wrapped in sterile sheets or towels without other medication until the definitive dressing can be carried out. In our clinic as well as several others, burns are no longer debrided except under special circumstances. This method was first adopted at the time of the Coconut Grove disaster and has the following rationale as summarized by Cannon (1944) "No debridement of the burned sur-

faces was done because evidence accumulated indicated that an increase in contamination of the wound resulted. Only by vigorous scrubbing of the surface could this contamination be reduced. However, the trauma of such scrubbing necessarily causes damage to viable cells and reduces the effectiveness of the important factor of tissue resistance in preventing invasive infection." A fine mesh gauze is placed on the burn without rupturing the blisters. This plan is justified by the absence of bacterial growth in cultures of blister fluid taken at intervals after the burn. The outer wall of intact, or even of ruptured blisters, acts as a protective membrane and may be considered as Nature's dressing for the ideal covering for a burn. Dingwall and Andrus (1944) in their study of experimental burns in human volunteers noted three instances in which blisters were still unperforated and the fluid had been reabsorbed while the lesion had healed at the end of seven days. The nature of the fine mesh gauze to be placed over a burn or its unruptured blisters is largely an academic problem at the present time. Vaseline, zeroform, sulfonamide, or plain dry or saline gauze may be used. Owens (1943) of the Ochsner Clinic is an especial advocate of saline gauze. Boric acid ointment may lead to toxicity in extensive burns, while absorption of too much sulfonamide may occur if a water-based sulfonamide ointment is used. It thus seems logical that the simplest and blandest covering for the burn is best. Dr. Lund of Boston (1944) is in agreement with this, stating "I have become such a therapeutic nihilist on the subject of chemical applications to the surface of burns, that, as some people know, we have given up any application now except dry gauze, counting on rest, pressure with or without plaster, as creating as good conditions as we know of for the healing of a burn, and allowing those dressings to remain up to three and even four weeks." Over the fine mesh gauze should be placed a liberal amount of fluffed mechanic's waste, and the final layer of the dressing should be formed of an elastic bandage. Thus a uniform pressure is the desired result. Such pressure can be accomplished over the extremities with ease and over the face and head if the surgeon is willing to take the time to do it. Over the trunk such a dressing is somewhat difficult to put on large subjects, but is always possible. The change of such a dressing should preferably not be done for ten to fourteen, or even twenty-one, days. Dr. Lund of Boston epitomizes this as follows: "The less often you dress a burn the faster it heals." After the dressing is removed the ideal thing is to get the burned surface in shape for grafting as soon as possible. An advantage of the pressure method dressings is that fewer burns need to be grafted. When grafting is necessary the application of pyruvic acid as advised by Connor and Harvey (1944) offers considerable promise in extending the removal of sloughs. In experimental animals the slough can be removed in 48-72 hours

with immediate grafting of the wound. This, of course, deserves further study before it is applied to human beings.

B. *Plaster Casts.* The article by Levenson and Lund (1943) summarizes the use of such casts in twenty-two burn patients. The casts are applied skin tight and the principle is the same as that of a pressure dressing. These casts are especially applicable to the extremities and provide ideal protection against outside infection and trauma of transportation. Swelling is prevented and the results seem good.

C. *Bunyan Bags or Envelopes.* The latest report on this type of burn treatment is that of Osborne (1944) appearing in the British Journal of Surgery. This author used Bunyan bays in eighteen cases of burns in the past nine months with good results.

II. Early General Treatment of Burn Shock (0-48 hours)

The most important item in the treatment of shock is to provide adequate fluid therapy. Oligemia is the most important general result of a serious burn and thus its control is the most important side in general burn therapy. Several liters of plasma may be lost from and into the burn surfaces and such plasma loss should be restored. The quantitative estimation of the amount of plasma loss in experimental burns was first determined by Blalock in 1931. The amount of plasma that should be given can be calculated according to previously described formulas as follows:

RULES FOR PLASMA DOSAGE CALCULATION IN BURNS

I. *Clinical Observation.*

II. *First Formula (Author)*

50 cc. plasma for each per cent of body surface burned.

III. *Laboratory Formulas.* (All by author except where stated)

100 cc. plasma for each point hematocrit exceeds normal of 45, or:

(a) 150 cc. for each blood specific gravity increase of 0.001 over normal of 1.060 (Phillips).

(b) 300 cc. for each gram hemoglobin exceeds normal of 15 (Phillips).

(c) 50 cc. for each per cent hemoglobin exceeds normal of 100.

(d) 50 cc. for each 100,000 r. b. c. exceeds normal of 5 million.

The nomogram of Jenkins, Schafer, and Owens is a graphic representation of these formulas. Whole blood may be substituted for plasma when the latter is not available. Even when plasma is available, one liter of whole blood should be given for every two liters of plasma administered. In addition to whole blood and plasma, electrolytes are advisable in the early stages of burns. The recent work of Rosenthal (1943) and of Fox (1944) has indicated the possibilities of electrolyte therapy in burns. The subject of fluid therapy in burns has been reviewed by Moyer,

Coller, Iob, Vaughan and Marty (1944). Such solutions are preferably given by mouth and in severe burns as much as 6-8 liters may be given the first day. If the patient vomits, the amount vomited should be restored by mouth. 1/6th molar sodium lactate may be used as an electrolyte solution, but if the fluid is kept up for several days, as it should be in serious burns, a mixture of two parts of Hartmann's solution with one part of 1/6th molar sodium lactate forms the ideal sodium electrolyte mixture. Evans (1944) doubts the value of sodium lactate in burns and points out that the main emphasis should be placed on blood and plasma.

III. Late General Treatment of Burn Sepsis, Toxemia, Anemia, and Hypoproteinemia

The control of burn sepsis is much improved now that the sulfonamides and penicillin are available for this purpose. Each patient is given a prophylactic dose of 2 gms. of sodium sulfadiazine intravenously about three hours after admission. Subsequently, while sepsis still presents a menace, this drug is given by mouth in dosages of 6 gms. daily. Local sulfonamides are not used except in a relatively non-absorbable form because adequate local concentration can be obtained by general administration, and furthermore, powdered sulfonamides on burn surfaces may lead to overabsorption. Toxemia is prevented and controlled by adequate fluid intake, plus continuation of electrolyte therapy as outlined above. Two liters of Hartmann's-lactate mixture a day should be given for one or two weeks after serious burns. The control of burn anemia and hypoproteinemia is of vast importance. This should be accomplished with adequate and frequent transfusions of blood, amino acids by vein, and most important, a high-protein diet giving 150-200 grams of protein per day with adequate vitamins. Severe burns should get 1.0 gram of ascorbic acid a day.

IV. Early Plastic Treatment of Granulating Areas

This aspect of burn treatment has been considered previously by the author (1942 and 1943). In any case with granulating surfaces resulting from a burn, it is extremely important that grafting be begun as soon as possible. In all cases the so-called principle of closure of the wound should be carried out. As long as a granulating area is present the burn is not healed and the wound is not closed. No physician should treat severe burns who does not know when and how to skin-graft the resulting granulating surfaces. Any burn granulating surface more than two inches in diameter, or which appears that it will take more than three additional weeks to heal, should be skin-grafted.

Skin-grafting of burns is most simply done with the Padgett-Hood dermatome. The most recent developments in the use of the dermatome concern the use of fibrin cemented grafts as introduced by Sano (1943) and the application of transparent film

to the dermatome by Webster (1944). The Webster method involves the cementing of a transparent cellophane film to the roller surface of the dermatome. The skin-graft is then cut with the cellophane covered drum and comes off attached to the cellophane. The cellophane sheet and skin graft can then be taken away from the dermatome in one unit. Patterns can be cut, or the graft cut up into postage stamp grafts, with the cellophane still attached. This technical improvement gives a considerable aid in using the dermatome.

V. Late Plastic Treatment of Scars and Contractures

This aspect of burn treatment is considered in Brown and McDowell's recent book and since it is not necessarily the province of the doctor originally taking care of the burn it will not be considered in detail at this time.

SUMMARY AND CONCLUSIONS

The treatment of burns is a continuous process, with the early and late, local and general, primary and skin-grafting phases, accomplishing the most good when they are carefully correlated with each other.

The use of infrequently changed pressure dressings, the adequate and prompt treatment of burn shock, and the early skin-grafting of all burn granulating surfaces, are three of the most important principles of burn treatment.

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Medical Statistics of South Carolina

V. The Status of Specialization of Physicians in the state and among the graduates of the Medical College of South Carolina

A. M. LASSEK, M.D., PH.D.

There are a number of factors which may be important to the future of medicine in South Carolina. These are the following: the economic status and hospital facilities in each county; the number of students enrolled in the medical college; the quality of the students on graduation and finally the pre medic background of the accepted applicants to the medical college. Of all these, the economic condition may be the most difficult to alter. In fact, I believe the decision has already been made by some high ranking federal authorities that medicine is easier to change than any local economic situation. The South Carolina hospital facilities and the locations of the living graduates of the medical college has recently been reported.^{2, 3, 4, 5} The present study is an attempt to answer in part what our physicians do after graduation. Postgraduate accomplishments may be the criterion determining the value of our state medical school.

As in previous studies of a similar nature, the source of the information is the American Medical Directory of 1942.¹ The data for this directory was accumulated just prior to the onset of the current world war and is, therefore, indicative of normal times. It is hoped that the study will be accepted as purely non-critical and impersonal.

RESULTS

In 1942, South Carolina had 285 (20.0%) of 1,427 physicians who limited their practice entirely to a specialty and another 180 (12.6%) who were part time specialists.

The following is a list with the number of full-time specialists included in each: Surgery, 46; Ophthalmology, Otolaryngology, and Rhinology, 46; Public Health, 44; Internal Medicine, 32; Pediatrics, 23; Urology, 21; Radiology, 15; Orthopedic Surgery, 12; Obstetrics and Gynecology, 8;

The Author:

Dr. Lassek was graduated from the University of Tennessee Medical School (1936) and is now Professor of Anatomy at the Medical College of the State of S. C.

Psychiatry and Neurology, 7; Dermatology, 5; Proctology, 4; Tuberculosis, 4; Pathology, 4; Clinical Pathology, 4; Ophthalmology, 3; Obstetrics, 2; Otolaryngology and Rhinology, 2; Allergy, 1; Bacteriology, 1; and Industrial Practice, 1. In a state with 1,899,804 population, there were no specialists limiting their practice to Neurological Surgery, Plastic Surgery, Anesthesiology, Gynecology, Cardiovascular Disease, Gastroenterology, Psychiatry alone and Neurology alone (Table 1).

The values for the part-time specialists were the following: Surgery, 69; Pediatrics, 26; Obstetrics and Gynecology, 14; Obstetrics, 14; Ophthalmology, Otolaryngology and Rhinology, 8; Urology, 6; Radiology, 6; Industrial Practice, 6; Tuberculosis, 5; Otolaryngology, and Rhinology, 5; Proctology, 4; Anesthesiology, 4; Gynecology, 3; Ophthalmology, 2; Psychiatry and Neurology, 2; Dermatology, 1; Cardiovascular Disease, 1; and Pathology, 1. There were no part-time specialists in the following: Neurological Surgery, Orthopedic Surgery, Internal Medicine, Allergy, Tuberculosis, Clinical Pathology, Bacteriology and Public Health (Table 1).

Of the 465 full and part-time specialists in South Carolina, 101 (21.7%) had been approved or accredited by the Examining Boards in Medical Specialists of the Council on Medical Education and Hospitals. Only two states in the southeast, Arkansas and Alabama had a lower absolute number in this respect.

22 (1.5%) of the physicians practicing in South Carolina in 1942 had taken National Board examinations. Of the southeastern states, only Arkansas

had a lower number of physicians taking this examination.

The ten largest cities of South Carolina (Charleston, Columbia, Greenville, Spartanburg, Anderson, Florence, Rock Hill, Sumter, Greenwood, and Orangeburg) with 15.3% of the entire population had 84.6% of the full-time and 48.9% of the part-time specialists. Both considered together amounted to 70.8%. The urban centers, all those with 2,500 or more population, had 94.7% of the full-time and 84.4% of the part-time specialists or 90.8% when considered together.

The four richest counties of the state (Richland, Charleston, Greenville, and Spartanburg) had 68.0% of all the full-time and 28.9% of the part time specialists. Allendale, Bamberg, Calhoun, Clarendon, Fairfield, Hampton, Jasper, McCormick, Pickens, and Union had no full-time specialists. In the following counties, the only full-time specialist was in the Public Health field: Abbeville, Aiken, Barnwell, Berkeley, Colleton, Darlington, Dorchester, Edgefield, Georgetown, Horry, Kershaw, and Lee. The same 22 counties had 43 part-time specialists.

The Role of the State Medical College Graduates

Of the 1,102 living graduates of the Medical College of South Carolina in the U. S. in 1942, 534 (48.5%) were in general practice, 240 (21.8%) were full-time specialists, 163 (14.8%) were part-time specialists whereas the remainder (14.9%) were either interns, residents, retired, not in practice, or in some branch of the federal service. 158 of the 240 full-time specialists were in the state whereas 82 were located outside of the state. 112 of the part-time specialists were in South Carolina and 51 were located elsewhere. 71 of our graduates had passed the American Board of Specialties whereas only 9 had taken the National Board examinations. The following is a list of the main specialties with the number of full-time physicians in each: Public Health, 44; Ophthalmology, Otolaryngology and Rhinology, 38; Surgery, 26; Urology, 23; Internal Medicine, 17; Pediatrics, 17; Obstetrics and Gynecology, 9; and Radiology, 8. None of our graduates have become interested in Neurological Surgery; Plastic Surgery; Gynecology alone; Allergy; Cardiovascular Disease; and Gastroenterology as full-time specialties (Table 2).

I have studied the specialization of graduates of a medical school located in another region of the U. S. with about the same total number as ours. 36.3% of these graduates against our 21.8% became full-time specialists. 315.0% more of them had taken the American Board whereas 3,967.0% more had taken the National Board examinations (Table 2).

COMMENT

Previous statistical investigations have shown that in the past quarter century there has been a distinct evolution toward urbanization of physicians in South Carolina. 2. 3. 4. 5 If the plans of the

Federal Government materialize, then in the next quarter of a century or more there will be developed a trend toward medicine in which the county is the declared unit of action. Hospitals with proper and adequate personnel will be provided in the needy districts of the U. S. Adequate personnel may imply the assignment of various specialists to county health centers. One of the defense explanations of certain writers who favor private medicine is that much of the bad medicine in the U. S. is due to bad economics. This has been answered by a high ranking official in the Public Health Service that it is easier to change medicine than it is economics.

The present study indicates that there has been a greater urbanization of specialists in South Carolina than there has been of physicians in general. Where as 51.3% of all our physicians were located in our ten largest cities, 84.6% of all full-time and 48.9% of part-time specialists were located in the same cities in 1942. The 57 urban communities of South Carolina which had a population of 2,500 or over had 75.8% of all our doctors but 94.7% of the full-time and 84.4% of the part-time specialists. Only 5.3% full- and 15.6% part-time specialists were located in the rural centers. Part-time specialists were spread more evenly over the smaller sized urban centers.

The four counties which have the largest urban centers and are the richest financially had slightly over two-thirds of all the full-time and over one-third of the part-time specialists. These same counties had slightly over one-half of all the general hospital beds in South Carolina. There were 22 counties in South Carolina which have no full-time specialists in private practice.

35.4% of the specialists in South Carolina had passed the American Board of Examiners. The average for all the southeastern states was 32.1% in this respect. The percentage for one state outside of the southeastern region was 50.0%. 1.5% of all the physicians in South Carolina had taken the National Board examinations. The average for the southeastern states was 2.0% whereas in the extra-regional state quoted immediately above the value was 11.8%. The state in the southeast with the highest relative percentage of specialists and the greatest number taking the National Board examinations was North Carolina.

Slightly more than one-fifth of all the living graduates of the state medical college had become full-time specialists in 1942. Public Health led in the specialty selected with Otolaryngology, Laryngology and Rhinology; Urology; Surgery; Pediatrics and Internal Medicine being the main ones and listed in the order of their frequency. It is interesting that Public Health, which ranks first, is a socialized form of medicine. In comparison with graduates of certain schools outside of the southeastern region, there appears to be a reluctance to meet the requirements of the American Board of

Examiners and the National Board. Only 9 out of our 1,102 living graduates had submitted to the National Board of Examiners. There is an explanation for this which may or may not merit our serious consideration.

On final analysis, it appears that under private medicine in South Carolina, there has been an evolution toward urbanization of hospitals, general practitioners and overwhelmingly of specialists. This trend is antagonistic to the declared approach of the Federal Government which believes that adequate hospitals, personnel and medical care should be provided to all the people in each needy county or district in the U. S.

CONCLUSIONS

1. There has been an overwhelming urbanization of specialists in South Carolina.
2. The ten largest cities of the state had 84.6% of the full-time and 48.9% of part-time specialists.
3. The counties of Richland, Charleston, Greenville and Spartanburg had 68.0% of all the full-time and 28.9% of all part-time specialists.
4. The most popular specialties in South Carolina are the following: Surgery; Ophthalmology; Otolaryngology and Rhinology; Public Health; Internal Medicine; Pediatrics; Urology; Radiology and Orthopedic Surgery.
5. No physicians in South Carolina were listed in the following full-time specialties: Neurological Surgery, Plastic Surgery, Anesthesiology, Gynecology, Cardiovascular Disease, Gastroenterology,

Psychiatry alone and Neurology alone.

6. 21.8% of all the living graduates of the state medical college were full-time specialists in 1942. 14.3% were situated in the state. Public Health was the leading full-time specialty.

7. 14.8% of all the living graduates of the medical college were part-time specialists. 10.2% were located in the state.

8. By comparison with a school located in another region, we rank low in the number of graduates taking the American Board and National Board examinations.

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Choline in the Treatment of Jaundice in Infancy (Case Report)

CAROLYN MOORE McCUE, M.D., SPARTANBURG, S. C.

The artificial production of liver cirrhosis in animals has been used for several years to study forms of therapy. Lowry, Daft, and others reported the prevention of cirrhosis in rats on an alcoholic diet by the addition of choline, methionine or casein. They also showed a rapid regression of symptoms if these elements were used in treatment after the cirrhosis had developed. Broun and Muether have given choline to adults with portal cirrhosis and had regression of ascites and size of liver with general improvement. I have found no record of its use in children.

Report of a Case

Brenda P., a 15 month old white female, was first seen on Feb. 1, 1944, with the complaint of jaundice of one month's duration. At the onset she had moderate jaundice, pale stools and dark urine, but no fever or gastro-intestinal symptoms. Except for the jaundice she was apparently entirely well. After a trip to Virginia two weeks before, she developed

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Dr. McCue is a graduate of the Medical College of Virginia, class of 1941. She is now practicing pediatrics in Spartanburg. Her husband is a Captain in the Medical Corps of the United States Army.

a cold and icterus deepened. Pain in the abdomen with some obvious enlargement, and fever developed only two days before she was first seen. The appetite was poor, but there was never any vomiting or diarrhea. There were no hemorrhage phenomena.

Family history was not contributory.

Past history revealed that she had been mildly jaundiced at the age of eight months for a two week period. This had cleared without the appearance of other symptoms, without medical care.

Physical examination revealed a dehydrated, deeply icteric, acutely ill girl of 15 months. Weight was 26 pounds and 4 ounces. The temperature was 104

degrees. There was only slight injection of the pharynx. Heart was rapid, 140/min. and displayed no enlargement or murmurs. The B. P. was 120/60. The lungs were clear. A tense abdomen was distended by a large firm liver which extended to the umbilicus. The spleen was barely palpable. No ascitic fluid could be demonstrated, and there was no edema.

Laboratory studies revealed a catheterized urine with a deep yellow color of bile, 1 plus albumen, 8 white blood cells and rare red blood cell and granular cast. A few of the white cells were clumped. The stools were clay colored, and negative for blood, ova and parasites. Blood showed a hemoglobin of 60% with 2,930,000 R. B. C. and 9,800 W. B. C. with 33% polymorphonuclears, and 67% lymphocytes. Icteric index was high and total blood proteins 8.5 gms. per 100 cc.

She was given intravenous injections of 10% glucose 2 or 3 times a week for the next 3 weeks, as well as sulfathiazole in moderate doses, and a high protein, high carbohydrate, and low fat diet. Added vitamins B. C. and K were given orally. While she continued to stay deeply jaundiced and have the large liver, the temperature fell promptly and remained around normal in this period. Urine showed 8-10 W. B. C. and rare R. B. C. constantly with a 1 plus albumen.

When the fever recurred on Feb. 22, the case was discussed with Dr. D. Lesesne Smith who suggested she be sent to Dr. Sam Ravenel in Greensboro, N. C. for careful laboratory studies. She was hospitalized for 10 days. Dr. Ravenel reported the following tests. Icteric index was 75. Clotting time and fragility test were normal while the bleeding time was slightly delayed. Mantoux and Kahn were negative. Agglutinations for typhoid, para A and B, abortus and tularemia were negative. The Vanden Berg reaction was delayed and direct. The blood showed a hemoglobin of 70% with 3,250,000 R. B. C. and 7,200 W. B. C. with a normal differential. Urine was negative then. After a transfusion she clinically improved and returned home.

For another month the jaundice remained about the same, the pharynx showed moderate injection and the urine some pus cells. The appetite was fair, but the progress was stationary with the huge liver increasing in size. During all this time she was receiving intramuscular vitamin B twice a week and oral vitamins A, D, C, and K, with low fat and high carbohydrate and protein diet. Because she developed an urticaria to sulfathiazole on March 14, this was discontinued. During the mid two weeks in March she lost 1½ pounds and became even weaker.

On March 21, 1944, she was started on one gram of choline chloride daily by mouth, with all factors of diet and vitamins the same that they had been

for 6 weeks. Four days later there was an amazing clearing of the jaundice. The appetite improved almost dramatically and she became much stronger and more alert.

During the following 6 weeks on the choline, the pharyngitis has cleared, and the urine has become negative. The liver has measurably decreased in size to 4 cm. in the midline, 4 cm. in the mid-clavicular line and 2 cm. in the mid-axillary line. At the onset these figures were 6, 8, and 4 cm. respectively. The icterus index has reduced to 9. The total blood proteins on April 30, 1944, were 5.45 with albumen 3.1 and globulin 2.3. She has gained 2 1/4 pounds in that 6 week period. The hemoglobin rose to 90½ as she has gained greatly in strength. Except for the hepatomegaly the physical examination was negative.

COMMENT

While it is, of course impossible to draw conclusions from a single case observed for only 3 months, especially one in which the outcome is known to be variable, it was dramatic enough in its response to choline to be worth reporting. The diagnosis of hepatitis which was probably secondary to a nephritis and pharyngitis must have had a hepatocellular element to have responded so well to choline. In view of the prompt improvement here, it would seem to be worth employing this drug in a large number of cases so that more definite conclusions could be drawn.

SUMMARY

A case of jaundice, fever, and hepatomegaly in a 15 month old girl is reported. The diagnosis of hepatitis secondary to a nephritis and pharyngitis was based on laboratory findings. Three months of supportive treatment failed to produce any improvement. Choline chloride was started in doses of one gram daily, and was followed by marked clearing of the jaundice in 4 days. In the subsequent 6 weeks the liver has decreased in size and there has been complete disappearance of all other symptoms. This case is reported to stimulate further trial of the drug in infancy.

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The History of Urology in South Carolina

JAMES J. RAVENEL, M.D., CHARLESTON, S. C.

The history of urology in South Carolina may be said to have started in the colonial period but not practiced by specialists until about 1914. As in all other localities the general practitioner covered all fields until a comparatively recent date, some of them leaning more to one branch than the others. That urological problems absorbed the interest of some of these early physicians is well demonstrated by case reports found in the one hundred and fifty years of minutes of the Medical Society of South Carolina, the Charleston Medical Journal and Review, as well as articles by these men in early national journals.

It is interesting to follow through the years the development of knowledge and progress made in dealing with the various common disorders of the urinary tract. Perhaps a discussion of the entity rather than the man would create a different interest in the subject. Such an approach is rather a divergence from the usual which accentuates the characters and not the disease.

Spermatorrhea: To us this is simply the expression of an old chronic prostatitis and seminal vesiculitis, yet in the years gone by the diagnosis of spermatorrhea was common. How often do we hear it today? Ninety years ago—1850, Dr. Francis Peyre Porcher* writes of his treatment and good results obtained by cauterizing the posterior urethra with strong solutions of silver nitrate. In a measure not unlike our present treatment of these oft-times vexing cases.

Gonorrhea: In July, 1806, a lively discussion took place on the floor of the Medical Society of South Carolina on the query: Is the matter of gonorrhea capable of producing syphilis and vice versa? The members seemed quite divided on the issue but on June 1st, 1822, the court at Abbeville, South Carolina officially ruled that gonorrhea and lues venerea were one and the same disease. Praise be to Allah, the courts are not always correct. The history of the treatment of this disease from the time of the leech through the astringents, instillations, irrigations, vaccine, foreign protein, artificial fevers, to now the era of chemotherapy makes an interesting story but far afield of the purpose of this sketch.

Hydrocele undoubtedly was treated surgically long before our records bear any witness to the fact. There is a record in 1802 of an operation for hydrocele on a mistaken diagnosis and in 1844 Dr. Thomas Wells of Columbia describes his method of treating it by paracentesis but does not claim originality.

Stricture of the Urethra is a prominent malady mentioned in the earliest records. The treatment by gradual dilatation with bougies occupies much space in the old minutes and some of the old soft malleable bougies are still preserved in our museum.

The Author:

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In 1845 Dr. James P. Jervey* reports on the operation of external urethrotomy for the cure of stricture. So numerous are the reports that it impresses one, not only with the commonness of the disorder, but also the apparent inadequacy of the treatment.

Extravasation from the lower urinary tract first appears on our records in 1802, when Dr. Edward Darrell Smith* reports a case of what he thought was acute hydrocele with gangrene and sloughing of the scrotum. The patient had had a complete anuria, or what was more likely, complete retention, for two days from a stone in the urethra. At the end of this time a communication between the urethra and scrotum developed with the escape of urine into the scrotum. Today we would recognize this rather promptly as extravasation of urine and not as an acute hydrocele.

The same author reports in 1820 a case of a child with a stone in the urethra which finally caused fistulae to develop between the urethra, perineum, scrotum and rectum.

These two cases picture for us the two types of urinary extravasation—the acute and the slower or chronic form.

Calculus disease of the urinary tract came to America probably with the early settlers. I know of no study of the disease among the Indian. I have found one reference which states that Dr. Joseph Glover* was the first native South Carolinian to do a lithotomy, which was in 1808. It further states that two previous operations had been done here by Dr. Turner of Connecticut. Quite probably the honors go to Dr. Edward Darrell Smith* who in 1802 removed a stone from the urethra surgically while operating for extravasation of urine from the lower tract.

In 1850 Dr. Bentham H. Ripley* makes the first reference I have found to giant renal calculus which produced no symptoms, and he also records a case of ureteral stone with hydroureter and hydronephrosis presenting the symptoms of bladder stone. He operated for stone in the bladder, but if we stop to think, it is remarkable how many correct diagnoses were made by the older generations with nothing to aid them but a highly developed sense of observation.

The chemical study of the composition of stone is probably quite old. Dr. J. F. M. Geddings* eighty-six years ago—1855, makes a note of removing a bladder stone composed of ammonio-magnesium phosphate with fat in the center.

Two definite cases of foreign body as a cause of stone are recorded in 1876 and 1882 by Dr. J. C. Maxwell of Greenwood and Dr. A. A. Moore of Camden. In the practice of onanism a piece of straw broke off in the urethra of one and a catheter in the other. The straw with its incrustations was removed with forceps but the incrustated catheter required an external urethrotomy.

Kidney surgery: An accurate knowledge of the early renal surgery in South Carolina is hard to obtain. In my search the first record found is a report by Dr. J. W. Wyman of Beaufort in 1858, when he drained a right perinephritic abscess, removed a giant calculus and also a stone from the ureter. It is quite possible that others had done nephrolithotomy before this.

Dr. T. Gaillard Thomas* in 1882 records a case of abdominal nephrectomy for hydronephrosis, the fifty-seventh recorded case.

Dr. Manning Simons* in 1891 and 1894 writes on the operation of nephrorrhaphy. He states rather emphatically that the operation is not necessary in all cases of displaced or floating kidneys, as many cases of nephroptosis produce no symptoms and that operation is not always successful. Judging from the rather common operation of nephropexy in the early nineteen hundreds, Dr. Simons was ahead of his time in such observations. His mortality rate was 5%.

Dr. R. S. Cathcart* in 1898 did a complete nephroureterectomy for tuberculosis of the kidney. This was stated by Dr. Howard Kelley to be the seventh one recorded. The first recorded case I can find of tuberculosis of the kidney by a South Carolinian was made by Dr. Horlbeck* in 1855.

Prostatectomy was performed in Charleston on December 2nd, 1889 by Dr. R. B. Rhett.* He suprapubically removed the prostatic tumor. The next reference I have is that of Dr. B. W. Taylor of Columbia who did a suprapubic prostatectomy in 1894. He at the time recommended the two stage operation.

The beginning of modern urology in South Carolina probably was about 1907 when Dr. T. Prioleau Whaley of Charleston began using the cystoscope for diagnostic purposes. Dr. Asbury Coward of Columbia had a cystoscope at about this time but apparently he did not use it (letter from Dr. M. H. Wyman). In 1908 Dr. Whaley was joined by Dr. G. F. McInnes. Neither of these men confined their entire time to urology, however. The first two men in

South Carolina to limit their practices to urology were Drs. M. H. Wyman and W. R. Barron of Columbia. This was in 1914. Dr. Wyman began the study a little before Dr. Barron but Dr. Barron announced that he was limiting his practice shortly before Dr. Wyman did. Immediately following this Dr. E. C. Baynard of Charleston announced the limiting of his practice to urology and became the first full time specialist to occupy the chair of Urology in the Medical College of the State of South Carolina.

The outstanding contribution to the specialty by a South Carolinian was the work of Dr. T. M. Davis of Greenville on transurethral prostatic resection. His conversion of the unacceptable Stern's instrument into an acceptable one, his improvement in the technique of the operation and his popularization of the procedure are bywords in American medicine of today. His work has created interest and effort throughout the civilized world.

(I wish to thank Dr. O. T. Finklea of Florence for a list of references he very kindly gave me. I regret that I have not been able to obtain much data from the state as a whole.)

*Physicians residing in Charleston.

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The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price

Florence, S. C.

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ANNUAL MEETING CANCELLED

In deference to the appeal made by Justice Byrnes and the War Committee on Conventions, the Council of the South Carolina Medical Association has decided to cancel the Annual Session of the Association for this year.

Efforts will be made to hold a meeting of the House of Delegates. Time and place of this meeting will be announced at an early date.

STILL GOING STRONG

While attending a district medical meeting recently, we met one of our older members.

"How are you coming along these days?" was asked.

"I'm still on the job," he answered. "I've just finished forty-five years of general practice—and I haven't had forty-five weeks of vacation in all of those years."

"Who is doing your night work for you?" was the next question.

"I'm still doing it myself. I've told my people that I'll keep coming when they call, but that they had best go easy on night calls or I won't last too long."

Forty-five years of hard general practice and still going strong, without a complaint. Of such a man our Association is justly proud and we offer our congratulations and our best wishes for many more years of useful service to our former President, Dr. Jim DesPortes of Fort Mill.

MEDICAL MEETINGS

With large medical meetings being cancelled, it is incumbent upon county and district societies to make their gatherings an even greater source of information and scientific instruction.

No matter how many patients a physician may have to see in his office, no matter how many calls he may have to pay, no matter how tired he may feel—he owes it to himself and to his patients to slip away on occasion and to join his colleagues in

an evening of social intercourse and exchange of ideas. He will come from such a gathering not only refreshed but intellectually stimulated, if those in charge of such a get-together make the necessary arrangements.

Many of our larger county organizations have realized their responsibilities and the monthly meetings which they present are truly valuable. Many of our smaller county societies, however, have found it well nigh impossible to have meetings which are sufficiently attractive to bring out their members. The result is that some of these societies have practically "folded up for the duration."

Might we suggest two courses of action which these smaller societies might pursue. The first is through the district societies. Instead of one annual meeting, certain districts might well have two or three meetings during the year. Good talks and papers are not difficult to obtain. There are numbers in our Association who can furnish such.

The second course is through joint meetings of two or more county societies. We know of three groups of county societies which are adopting this plan — and the results are encouraging.

Physicians need to attend medical meetings, and it is the duty of county and district society officers to see that the opportunity is afforded for them to do so.

MEDICAL COLLEGE EXPANSION PROGRAM

The question of whether to adopt the proposed plan for expansion of the Medical College is now before the public. Physicians and members of this Association should be well acquainted with all the facts in the case so that they may discuss the plan with intelligence. These facts were given in a letter which was sent out by Dean Kenneth Lynch to physicians. The information in this letter is so vital that we publish it in order to make it a matter of record in our Journal.

"Recently a bid for a medical school at the University of South Carolina in a new location outside Columbia has appeared in the public press, giving the possible inference of opposing plans. This is

not necessarily true. The aims and plans of the two institutions are subject to cooperation and coordination to every advantage to both and to the State, while competition brings disadvantage to all and might cripple either or both.

"The purpose of this letter is to give you the reasons for retaining and maintaining the school in its present location as contrasted with the new position proposed, and the savings to be effected by our program.

"We start with the fact of the Roper Hospital, saving about 200 beds in construction, at a saving to the State in capital expense of at least \$1,200,000.

"Further, although parts of the Medical College plant are not new, on the whole it is good and should not be discarded. A complete new plant to replace it could not be constructed and put into use for under probably \$2,500,000.00.

"Also, we must remember that the annual cost of support of the Roper Hospital teaching patients is saved to the State. Last year that amounted to \$288,000.00.

"Therefore, in order to build what is already here, there would have to be a capital outlay of probably \$3,500,000.00, and to operate what is now free for our use would cost annually probably \$288,000.00. "Still further, the cost of employing such a staff as would be necessary for the hospital proposed at the University in its suggested location, while not now subject to accurate calculation, would most certainly be much greater than would the contemplated staff here under our proposed program.

"Incidentally, but very importantly, in considering the best opportunity for developing the State's medical school, it is well established in experience that a location within a populous center with ready access on the part of patients with the common every-day illnesses which constitute the main practice of the average doctor is very important. Medical schools which are not so located are at a distinct disadvantage and some have had to make special and expensive and troublesome arrangements to overcome it. At least one state medical school is now in the expensive throes of moving to such a location. University medical schools are commonly physically separated by various distances from the campus for this reason and many of the leading schools are thus dislocated. The present location of our school is definitely the best in the state, where it has a history and an experience which could not be purchased.

"When all elements are considered, therefore, it seems clear that to abandon what is already in hand and to build entirely anew elsewhere would not only set up disadvantages which would be very expensive to overcome but that the initial additional cost would run into the millions while the additional necessary annual appropriation from the State would be in the hundreds of thousands."

FROM WASHINGTON

Last year, the U. S. Senate Subcommittee on War-time Health and Education (Senator Claude Pepper, Chairman) held extensive hearings in Washington. Abstracts of some of the testimony presented have been presented in earlier issues of this Journal.

The report of this committee was issued recently. We present herewith those sections which are of vital importance to our Association and to each of our members. Those who wish further information should secure the complete report and also the full text of the hearings. (These may be obtained through a physician's local Congressman.)

Training for Demobilized Physicians

The quality of medical education in this country for the past two decades has been very high. The medical schools have rendered outstanding service in the war by increasing the annual output of physicians 30 percent despite serious depletion of facilities and unpredictable Army and Navy policies. But the accelerated undergraduate courses, and the shortened internships and residencies, will make it necessary to provide further supervised training for many recent graduates unless the future quality of medical and dental practice is to be jeopardized. Most of the young graduates are well aware of this. A majority of the replies to a questionnaire recently addressed to medical officers of the Army and Navy indicated a desire for refresher and advanced courses in medicine after the war. Many thousands of physician veterans will receive post-graduate training at Government expense under the terms of the G. I. bill of rights. Neither the need nor the demand for post-war advanced medical training can be met with the graduate teaching facilities and staffs now available in medical schools. Expansion of such facilities through increased provision of teaching hospitals and medical centers, as part of the program herein-after described and recommended, will therefore be required.

Distribution of Medical Facilities

The quality of American medicine at its best is very high. Unfortunately, American medicine at its best reaches only a relatively small part of the population. One of the greatest benefits of modern, scientific medicine is the early detection of conditions which, if neglected, may become seriously incapacitating or even fatal. Vast improvement is needed in the application of known diagnostic procedures. Only a negligible proportion of people get a periodic physical check-up. Fifty-five percent of all cases of tuberculosis admitted to sanatoria are in an advanced stage of the disease at the time of first admission. Many patients have cancer for months, or even years, before the disease is discovered, and a substantial number of cases remain undiagnosed until cancer has caused death. There is widespread neglect of prenatal care by which both maternal and infant death rates could be considerably reduced.

The reasons for the failure of medicine to apply more widely the known diagnostic and preventive techniques are many and complex. One very important reason is the lack of physical facilities and equipment in many parts of the country. Good medical practice today requires a concentration of skilled personnel and equipment that is found only in good hospitals, medical centers, or group clinics.

Whereas the national ratio of general hospital beds was 3.4 per 1,000 population in the years just before the war, the ratios in such States as Mississippi and Alabama were less than half that. According to the Surgeon General of the United States Public Health Service, 40 percent of our counties, with an aggregate population of more than 15,000,000, have no registered hospitals. Many of the counties with hospitals have poor ones, even though they are registered.

A study conducted by the American Medical Association showed that only 2 percent of the population did not reside within 30 miles of some hospital, but this does not indicate the quality of the institutions, whether or not they have vacant beds, whether or not patients are financially able to use them, or whether racial barriers or legal requirements concerning residence prevent their utilization by all who live in the vicinity.

Distribution of Physicians

Shortages of doctors, dentists, nurses, and other medical personnel are marked in many communities, and, in general, medical personnel are inequally distributed throughout the country. For example, in 1944 Massachusetts had about 3 times as many active physicians in proportion to population as did South Carolina. Similar disproportions exist between other States and between local areas within the same State. Counties with more than 5,000 population may be without a single physician, while other counties in the same State may have 1 active physician for each 1,000 people.

Extensive studies conducted by the United States Public Health Service show that the distribution of physicians is influenced by several interrelated factors, among which are community purchasing power, adequacy of hospital facilities, degree of urbanization, proximity to medical schools and teaching hospitals, and presence of professional colleagues. Of these factors, the first three are probably the most significant, and community wealth is probably the most important of all. In 1938, counties with per capita income of more than \$600 had 8 times as great a proportion of physicians to population as did counties with per capita income of less than \$100.

Rural areas are generally less well supplied with physicians than urban areas. Strictly rural counties in 1938 had only about one-third as many physicians in proportion to population as did urban counties. Recent data supplied by the Procurement and Assignment Service show that the 81 counties reported to have no active physician, as well as the 141 coun-

ties reported to have more than 5,000 inhabitants per active physician, were practically all rural. The wealthier rural areas are better supplied than are the poorer rural areas, but even the wealthiest group of rural counties in 1938 had 30 percent fewer physicians in proportion to population than urban areas with the same per capita income.

The shortage of physicians in rural communities is not due to less need for medical care than in cities. Studies made by the Farm Security Administration suggest that the burden of illness in rural areas is the same as, or greater than, in urban centers.

Situation Grows Steadily Worse In Rural Areas

Despite this need, medical graduates have shown increasing reluctance in recent decades to settle in rural communities. In North Carolina, for example, the number of doctors in strictly rural areas fell from 1,125 in 1914 to 719 in 1940. In that year 73 percent of the population of the State lived in rural areas, although such areas contained only 31 percent of the State's physicians. The burden of caring for rural patients falls increasingly on the older practitioners who, despite sometimes heroic efforts, are frequently unable to do the work demanded of them.

There is no doubt that lack of hospitals and diagnostic facilities is one of the most important factors in keeping doctors away from rural practice. In fact, the presence of hospital facilities alone, independently of such factors as community wealth and size of population, appears to attract physicians. This is suggested by a United States Public Health Service study which shows that among counties with per capita income of less than \$300, those with no general hospital beds had 60 percent fewer doctors in proportion to population than did those with 250 or more general hospital beds.

Many crowded war-industry and extra-cantonment communities are also suffering from a severe shortage of doctors. In some places shortages have been relieved by relocation of physicians through the Procurement and Assignment Service of the War Manpower Commission, but in others the situation remains critical and without hope of relief except through assignment of Public Health Service physicians, a proposal which Congress has rejected. Data submitted by the Procurement and Assignment Service show that at the end of 1943, 553 counties had more than 3,000, 141 counties had more than 5,000, and 20 counties had more than 10,000 people per active physician in private practice. In addition, 81 counties, 30 of which had populations of more than 3,000, had no practicing physician.

The wartime shortages are merely sharper manifestations of the long-standing and steadily growing maldistribution described above. There is every indication that maldistribution will become even more marked after the war unless effective steps are taken to reverse the trend. As the older physi-

cians who remain in rural communities die or retire the situation becomes increasingly critical. Polls of the opinions of young Army and Navy doctors show that the vast majority want specialist training and practise, preferably with a group. Only 12½ percent indicated a desire for rural practice. We may therefore expect the younger doctors and dentists to continue to shun the countryside unless they are offered good professional surroundings, including modern hospital facilities and an opportunity to earn a good living. Without such positive incentives the opportunity for better distribution presented by release of medical personnel from the armed services will be lost. More uniform licensure laws are also needed.

The Medical Center Idea

Hospitals were formerly considered only as places in which to care for the seriously ill, and even today many hospitals are nothing more than that. Modern programs of hospital construction should have as their aim the ample provision of a more inclusive type of hospital service. The subcommittee has studied with interest the growing trend toward utilization of a relatively new type of facility called a medical center, which combines and coordinates the three major aspects of modern medical care—the preventive, the diagnostic, and the therapeutic services. The medical center brings together doctors' offices, diagnostic and laboratory equipment, hospital beds, and preventive work. It furthers group practice by physicians, surgeons, and dentists; encourages experimentation and research; and stimulates dissemination and exchange of medical knowledge.

This principle of combining the preventive, diagnostic, and curative services of medicine into a single functional unit, here called the medical center, has been advantageously applied on a large scale in certain great university centers. It is also applicable, however, to the smaller-scale needs of rural communities throughout the Nation. The establishment of a network of "outpost clinics," to use the phrase of a representative of the American Medical Association, the creation of "diagnostic centers," as urged by the Surgeon General of the Navy, and the "expansion of the present functions of the hospital," advocated by the spokesman of the American Hospital Association, appear to be expressions of the same basic aim—the provision of facilities suited to the practice of modern, scientific medicine.

Planned Network of Facilities Urged

Terminology in this field is far from uniform. The Surgeon General of the United States Public Health Service urged development of a coordinated network of four basic types of medical center facilities—the small neighborhood or community "health center," the "rural hospital," the "district hospital," and the large "base hospital."

The physical structures required for many of these four basic types of units already exist in many

areas. Here the primary need is for regional planning and organization of the existing facilities so that they might function in a coordinated manner, rather than for the construction of new buildings. In some places, minor alterations, renovations, or addition of new wings, might suffice to convert existing public or voluntary institutions into units of the coordinated regional plan.

The smallest unit, the health center, might include offices for local physicians and dentists; facilities for emergency medical and surgical work; a small number of beds for obstetrical care; laboratory facilities for X-ray, blood, and bacteriological procedures; and health department offices and clinics where these are not otherwise provided.

The rural hospital, located within easy reach of several health centers, would be larger than the health center and would provide additional basic medical, surgical, obstetrical, and laboratory services. The size of the rural hospital would depend upon the needs of the area it served, but it should be a modern hospital in every sense of the word.

Many of the health centers and rural hospitals probably would serve areas which could not support specialists' services of their own. Therefore, such services would be provided through district hospitals, located so that they could conveniently serve several rural hospitals. Local needs and preferences might determine whether patients from the rural areas were transported to the district hospitals or whether the specialists from these hospitals visited the smaller units periodically. In most instances the district hospitals would provide nurse training and instruction for interns, including discussion of complex cases and of medical advances.

Base Hospitals

Finally, as the hub of each major medical service area, there would be a large base hospital. In most cases the major service area would be a State, though some States might have more than one major service area, and in some instances a base hospital might serve two States or sections of two States. The base hospital would be a teaching hospital, staffed with experts in every medical and surgical specialty, equipped for complete diagnostic services, and designed to conduct extensive postgraduate work and research. Besides its general hospitals beds, it would have, either on its premises or nearby, facilities for institutional care and study of tuberculosis, nervous and mental disease, contagious disease, and orthopedic and chronic disease. The benefits of the research carried on in the base hospital would be passed on to the smaller units in the network, and there would be constant back-and-forth referral of patients and diagnostic information, as well as interchange of personnel, between the large center and the smaller institutions.

With such graded networks—the health center, the rural hospital, the district hospital, and the base hospital—covering the entire country, facilities

would be available through which every person, regardless of where he lived, might receive (a) immediate diagnosis and care for the common, relatively simple ailments and (b) easy access when necessary to the more complicated types of medical service.

The development of such a network of medical centers would constitute a great step toward the goal of providing a high quality of medical service everywhere in the Nation. It would enable communities to cope much more adequately with the medical needs of war veterans and their families. It would also create opportunities for group and individual practice for the 40,000 medical and dental officers who will return from the armed forces, as well as for returning nurses and other health personnel.

Health Department Centers

Local health departments should be moved from the musty basements of county courthouses and city halls to modern, well-equipped buildings where the health officer and his staff could efficiently carry on their very important activities.

The American Public Health Association has proposed the creation of approximately 1,200 public health districts of roughly 50,000 population each, with at least one district health center and one sub-center in each district. These health department centers could in many instances be included in the medical center type of facility described above.

With improved facilities the health departments could undertake expanded public health programs designed to eradicate venereal disease, tuberculosis, malaria, and hookworm; to lower maternal and infant mortality; and to promote health through education. Cooperation would be fostered between the health department and local private practitioners, and both would benefit by a more comprehensive approach to the health problems of the people.

Achieving a Health Facilities Program

According to careful estimates made by the United States Public Health Service, facilities are needed for 100,000 new general hospital beds, 94,000 new nervous and mental hospital beds, and 44,000 tuberculosis beds. In addition, 66,000 general beds, 97,000 nervous and mental disease beds, and 16,000 tuberculosis beds are situated in hospitals that are obsolete and that should be replaced. Approximately 2,400 modern structures are needed to serve as headquarters for local health departments.

A program for construction of these facilities would have to be well-planned and well coordinated, in order to avoid the mistakes which characterized the construction boom following World War I. Areas which need hospitals most should be given priorities for building materials and surplus medical supplies. The hospitals should not only be planned and built along modern, functional lines, but should be staffed and maintained so as to assure a high level of operating efficiency. Voluntary and public

hospitals should work together in a coordinated manner. Both, in turn, should cooperate with the health department and private practitioners.

The cost of an adequate health-facilities program cannot be borne by the States and localities alone. Federal grants-in-aid to the States on a basis of need will be necessary.

In order to permit local initiative and control, State programs should be drawn up by State health planning commissions in cooperation with local authorities. Such commissions, consisting of representatives of professional groups and the public, could be appointed by Governors in States where they do not now exist. In drawing up State plans the commissions should consider the needs of all sections of the State, should include in the plan all suitable existing public and voluntary hospitals, and should plot the new construction as well as the expansion or replacement of existing facilities needed for adequate service. Before Federal funds could be granted, however, over-all State plans and individual projects should be reviewed and approved by the United States Public Health Service to make sure that they meet certain minimum standards of construction, operation, and complete, coordinated service. There should be reasonable assurance that a new facility will have enough patients to justify its existence. In communities where sufficient income from fees of individual patients does not otherwise appear probable, provision for group prepayment plans or tax-supported services, or both, should be required.

Grants to both public and voluntary institutions included in the plan would be administered through a State agency, in most cases the State health department. To insure continued representation of the public, health advisory councils should be appointed to confer with the State agency administering the plan.

Payment For Medical Care

Much has been said and written about the financial barriers to good medical care. There is general agreement that good medical care is necessarily expensive; that the burden of illness is unpredictable and falls unevenly, striking one family much harder than another; that sickness comes unexpectedly and may wipe out the laboriously acquired savings of an entire family; and that for these reasons a considerable part of the population does not receive either the amounts or the quality of medical care it needs and should have.

Care Received Varies With Income

Other studies, particularly those of the Committee on the Costs of Medical Care, show that low-income families not only spend less for medical care but also receive much less care than those with higher incomes. The highest income group in 1929 received more than twice as much physician's care and more than three times as much dental care as did the lowest income group. Yet it is the low-income group

that needs the most medical care. Sickness and poverty go together. In 1935 wage earners in families with incomes under \$1,000 per year suffered about twice as many days of disabling illness as did workers in families with incomes over \$3,000, according to the National Health Survey. Facts do not support the observation that "the poor and the rich receive the best of medical care; only the middle class suffers." High-quality care on a charity or low cost basis is available to the poor in relatively few places. Even in those places, low-income families are often reluctant to accept charity.

In 1933 the Committee on the Costs of Medical Care estimated that adequate medical and dental care, with proper remuneration for those furnishing the service, could be provided at an average annual cost of about \$125 per family. Since this estimate was made, prices of medical goods and services have risen so that the figure would probably be about \$150 if it were brought up to date. Other authorities, however, place the average cost of providing adequate services at a much higher figure. It is evident from studies of family budgets that the 50 percent of our families with incomes under \$2,000 cannot afford to pay even \$150 a year for medical care and that this amount imposes hardship upon many families in the \$2,000 to \$3,000 income group. The result is that doctors' bills pile up and many people will not call a doctor until they are seriously ill.

Fee-For-Service Versus Insurance

Evidence such as this leads the subcommittee to conclude that the "pay as-you-go" or fee-for-service system, which is now the predominant method of payment for medical services, is not well suited to the needs of most people or to the widest possible distribution of high-quality medical care. It tends to keep people away from the doctor until illness has reached a stage where treatment is likely to be prolonged and medical bills large. It deters patients from seeking services which are sometimes essential, such as specialist care, laboratory and X-ray examinations, and hospitalization. Individuals with low incomes, whose need is greatest, are most likely to postpone or forego diagnosis and treatment.

The solution of this problem will not be easy. Undoubtedly it lies in some form of group financing which would make it possible to share the risks and distribute the costs more evenly. This might be achieved by voluntary or compulsory health insurance, by use of general tax funds, or by a combination of these methods. Insurance methods alone would not be enough, because they are not applicable to the unemployed or to those in the lowest income groups.

In order to meet the requirements of the public and of the professional groups concerned, any method which is evolved should offer complete medical care, should be reasonable but not "cut rate" in cost, should include substantially all of the people, should afford the highest quality of care, should

permit free choice of physician or group of physicians, should allow democratic participation in policy making by consumers and producers of the service, should be adaptable to local conditions and needs, and should provide for continuous experimentation and improvement. Insofar as possible, it should also avoid the charity relationship.

Voluntary Versus Compulsory Insurance

The way in which these aims can best be achieved is now the subject of considerable debate. Advocates of voluntary health insurance, such as the Blue Cross hospitalization and the medical society prepayment plans hold that such plans will fulfill all needs if given sufficient time, and if supplemented by tax-supported grants for medical care to all recipients of public assistance. Others believe that only a small percentage of the population will ever obtain complete medical care through voluntary prepayment plans, and propose compulsory health insurance along some such lines as those set forth in the Wagner-Murray-Dingell (S. 1161, 78th Cong.) Still others maintain that needs would be met most satisfactorily and economically through a universal system of tax-supported medicine. At this stage of its investigation, the subcommittee is not prepared to pass judgment on these differing opinions. It is in agreement, however, with those who feel that remediable action is overdue and should not be long delayed.

Pending the achievement of a solution which will assure complete medical, dental, and hospital care for the whole population, more adequate provision should be made for medical care of the needy. This will require increased appropriations by local, State, and Federal governments. Under the Social Security Act, Federal funds are granted to State programs for aid to the needy aged, the needy blind, and needy dependent children. Federal funds can be used for medical care of individuals in these categories if the State law so provides, but in most States medical care is not included among public-assistance benefits. Furthermore, Federal funds are not available to State programs for aid to needy individuals other than the aged, the blind, and dependent children. Legislation introduced in the 78th Congress provided for amendment of the Social Security Act so that Federal and State funds would be available to help States finance medical care for the needy, regardless of category. Proposals have also been made to alter allotment procedures governing distribution of Federal funds to State public-assistance programs so that more money could be given to States where needs are greatest. These measures, if approved, would help relieve the financial load on hospitals and practitioners, who now give a great deal of free care. Such relief for hospitals and physicians would permit them to lower their charges to prepayment plans and thus encourage the enrollment of more people from the group able to bear the average cost of medical care.

Medical Research

Magnificent progress has been made in medical research during the war. The curative powers of penicillin and of the sulfa drugs, the life-saving value of blood plasma and serum albumin, the efficacy of D. D. T. powder and typhus vaccine, and the development of new malaria-control methods are all fruits of a concentration and expansion of medical research resulting from determination to win the war. Adequate financing, coordination, and teamwork have been the keys to this success. Through governmental agencies such as the Army, Navy, and the Office of Scientific Research and Development, and non-governmental agencies such as the National Research Council, the universities, and other groups, the Nation's resources for research have been mobilized in a vast cooperative effort.

With victory in sight, we now approach the challenges of peace. Many problems await solution. Much long-term as well as short-term or "practical" research into the causes and cures of cancer, arteriosclerosis (hardening of the arteries), hypertension (high blood pressure), dental decay, and nervous and mental disorders must be undertaken in order to assure further progress against disease.

The Office of Scientific Research and Development has served well as an emergency agency through which to channel Federal aid for medical research. Federal aid must continue if the great possibilities offered by medical research are to be realized. The way in which Federal aid is to be given and administered must now be carefully considered.

Government cannot, and must not, take the place of philanthropy and industry in the sponsorship of research. It is essential, however, for the Federal Government to provide resources for coordinated attack on medical problems which affect the country as a whole. In no other way can science be given full freedom and opportunity to serve the Nation in peace as it has in war.

Education, Legislation, and Organization

The subcommittee recognizes the complexity of the task of providing good medical care to all the people. We believe that there are three necessary methods of approach to this task. One approach without the others would be unrealistic and ineffective.

The first involves education of the people, of the professions, and of the Government. We must collectively accept the fact of widespread existence of disease, disability, and injury, much of which medical knowledge today is able to prevent, alleviate, or cure.

The second approach is through legislation. There is urgent need for modern medical facilities in many places throughout the Nation, especially in rural areas and in crowded war-industry communities. To meet these needs money must be provided, and Federal financial assistance will be necessary.

The third approach is through better organization of medical services. There is wide agreement that

improved organization would result not only in a higher quality of service but in considerable economy of time, effort, and money. The necessary reorganization can best be achieved, and the welfare of the professions and the public advanced, by regional planning such as that provided for in the health and medical center proposal set forth above.

Recommendations

On the basis of the preliminary findings outlined above, the subcommittee—

1. Recommends that Federal grants-in-aid to States be authorized now to assist in post-war construction of hospitals, medical centers, and health centers, in accordance with integrated State plans approved by the United States Public Health Service.

2. Recommends that Federal loans and grants be made available to assist in post-war provision of urban sewerage and water facilities, rural sanitation and water facilities, and milk pasteurization plants, in communities or areas where such facilities are lacking or inadequate.

3. Urges State and local governments to establish full-time local public health departments in all communities as soon as the needed personnel become available. With this aim in view, consideration should be given to rearrangement and consolidation of local health jurisdictions and to amalgamation of existing full- and part-time local health departments with overlapping functions. The Federal Government should increase the amount of its grants to State health departments to the end that complete geographic coverage by full-time local health departments may be achieved and that State and local public health programs may be expanded in accordance with needs.

4. Recommends that the Army consider the feasibility and advisability of expanding its program for induction and rehabilitation of men rejected because of physical and mental defects.

5. Recommends that the medical records of the Selective Service System be preserved and that funds be appropriated for further processing and study of these records.

6. Reports the acute shortage of personnel with training in psychology and psychiatry and the need for immediate steps to increase the output of such personnel with a view to providing child-guidance and mental hygiene clinics on a far wider scale.

7. Recommends that Federal scholarships or loans be made available to assist qualified students desiring medical or dental education; urges that increased enrollment of women in medical and dental schools, and premedical and predental courses, be encouraged in every way possible.

8. Recommends that Federal funds be made available to States for medical care of all recipients of public assistance and that allotment formulas governing distribution of Federal funds to State public assistance programs be made more flexible in order to give more aid to States where needs are greatest.

The recommendations made above should be put into effect as soon as possible. We should begin planning now for the reconversion period. Further delay will postpone orderly solution of our health problems and deprive us of an effective means of aiding industry to maintain full production and employment after the war.

A comprehensive health-and medical-facilities program, planned now and undertaken as soon as materials and labor become available, would soon

pay big dividends in improved national health and physical fitness. We have seen what neglect of opportunities for better health has cost us during this war. We should resolve now that never again, either in war or in peace, will the Nation be similarly handicapped.

January 2, 1945

Claude Pepper

Elbert D. Thomas

Robert M. La Follette, Jr.

The Ten Point Program

M. L. MEADORS, EXECUTIVE DIRECTOR AND COUNSEL

CURRENT TRENDS

While it is impossible to draw from the complicated mass of expressions in and out of Congress and the other departments of the Government, any definite line of development in the medical care situation, the trend of the immediate present seems to be away from the principles of the Wagner-Murray-Dingell Bill and toward some other form of Government participation. Such indications are reflected in the testimony offered at the hearings before the Pepper-Sub-Committee during the past year, and the expressions of Senator Pepper and others from time to time in connection with the remarks of the witnesses who testified before the Sub-Committee.

It goes without saying that the reason for the flagging interest in the Wagner-Murray Dingell Bill is the fact that public opinion has made itself felt. The idea that the Federal Government should assist in some way in a nation-wide program for the improvement of medical care is as thoroughly alive as ever and, frankly, we think it should be. The question is not the desirability of some such assistance from the Federal Government but the form that it shall take. The direction in which the signs point at this time is a bit encouraging.

The trend now seems to be toward development of a plan for federal grants or subsidy payments to the states, probably through the Public Health Service, for use in connection with the construction of hospitals and hospital facilities, the financing of scientific research in the field of medicine and medical care, the furnishing of financial aid to worthy young men and women interested in obtaining medical and nursing educations and in the construction and improvement of physical plants of medical colleges. Such funds as might be provided under this program would doubtless have to be matched by the states in which they are spent and this, of course, is desirable and necessary. Without the financial stake in any such program, local authorities would have little claim to the right to exercise any control of the administration of the funds.

In connection with the testimony at the hearings referred to above, Senator Pepper is reported to have said that he was wondering if his committee might recommend to Congress that instead of trying to settle all of the controversy about compulsory medical insurance, an adequate matching system might be set up. He pointed out that the Federal Government soon will have available a lot of surplus equipment and, that under the law, those facilities which the Veterans Administration doesn't want, may be made available to political sub-divisions of the several states on either a lease or sale basis.

Another expression attributed to the Senator in this connection is of special interest. He is reported to have suggested the possibility of county or township cooperatives and provision for subsidies to all such voluntary systems. As he pointed out, if through such subsidies the voluntry systems are started with full coverage and a family holding membership in such a system gets all its medical care for a few dollars a month, their neighbors will soon realize the advantage and seek membership also.

While, of course, these and many other expressions which might be referred to are nothing more than indications of a trend, they are, we believe, hopeful. One thing is practically certain — out of the mass of testimony and exhibits introduced before the Pepper Sub-Committee, there will come proposed legislation, in all probability to be substituted in the place of the now dormant Wagner-Murray-Dingell Bill. The President recently, when signing the bill which froze social security taxes at their previous level, stated that he would propose in the near future a thoroughly comprehensive plan for social security, including, by implication if not expressly, the subject of medical care.

It appears therefore that the role of the medical profession at this time should be that of friendly adviser and constructive critic, *amicus curiae*, so to speak. Now is the time to take advantage of such opportunity as is afforded — and we believe that there is a real opportunity — to cooperate in working out a constructive program which will be in the

public interest and which, while furnishing the desired improvement, will not interfere with the American tradition and professional principles of free choice of physicians by patients and the rendition of medical care on the "free for service" basis.

On the other side of the picture, however, it is clear that Senator Wagner and those who share his views have not given up in their aim to effect the passage of a law providing for tax-supported medical service on the basis of social security. Writing in the January issue of *Fortune* magazine Senator Wagner, referring to the article in the December issue of *Fortune* on "U. S. Medicine in Transition," expressed himself in no uncertain terms. Conceding that the editors were right in stating that some change in the method of administering medical care is eminent, he said, "But I think they err in indicating that our medical needs can be met through voluntary forms of doctor-patient cooperation." He referred to the experience of Michigan and California in their first efforts to provide complete medical care through voluntary organizations and apparently drew the conclusion (which does not necessarily follow) that no such plan on a voluntary basis is feasible.

Definite proof of the direction of Senator Wagner's further efforts is to be found in this sentence with which he concluded his letter. "If we want all Americans to have adequate medical care, it must be done by utilizing and expanding existing personnel and facilities, in cooperation with the professions and with the financial resources and coverage which only a comprehensive government program can assure."

In the same magazine there appears a letter from Mayor LaGuardia, referring to his proposed Health Insurance Plan of Greater New York. He concluded his letter with this statement: "I do not believe that the people of this country will wait much longer to banish the economic phantom which haunts families when sickness strikes. Our city, through the Health Insurance Plan of Greater New York, is taking a sound and practical step to meet the most important need of our people in the spirit of the times in which we live."

Representing a slightly different, though related, viewpoint is the letter of Dr. Garfield, Medical Director for the Kaiser Plan. He said, "I agree with you thoroughly — the issues are squarely up to the physicians. Through intelligent, cooperative planning and organization they could meet the medical needs of the people. The government could help by making funds readily available for new facilities. If the physicians fail to do their part it will be necessary and inevitable for the government to assume the complete responsibility of medical care in this country."

Justly so or not, we cannot escape the conclusion that the expression last quoted above is a pretty accurate summation of the matter as it now stands. Whether or not the physicians are responsible in any appreciable degree for the current demand for a change, it is undoubtedly true that they will be expected to bring it about on a large scale, both because there are many people who feel that the responsibility is theirs and also because of the fact that it is in the interest of the medical profession to do so.

Again we say, there is real opportunity now for the profession to do great service to itself and to the country as a whole through cooperation, reasonable concession on points which do not involve principle, and through constructive planning and suggestion in a spirit of willingness to work together, with laymen more interested in the social side of the problem.

THE BLUE CROSS BILL

As this is written, plans are complete for the introduction of a proposed bill before the General Assembly to provide for the organization of a Non-profit Hospital Insurance Corporation according to true Blue Cross standards. We hope by the time this is read, the bill will be well on its way to final adoption in both houses and approval by the Governor.

The minimum capital required under the proposed law is \$25,000. With this exception the bill is substantially the same as was introduced last year but it failed to pass.

On December 28, descriptive material on the Blue Cross plan was mailed from this office to each member of the Legislature. On January 2, similar material was sent to all members of the association. We know of the efforts already put forth by some of the doctors and these will be of untold value.

If the bill has not yet been passed when this appears, it is hoped that the activities of all those interested will be continued or renewed.

There is no better way to prove the absence of necessity for compulsory, government controlled and administered insurance than by creating in every state the opportunity for voluntary insurance against the hazards of hospital and medical expense, on a comprehensive basis.

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THE GREENVILLE HOSPITAL ASSOCIATION

Of interest at this time, in view of the effort being made to secure adequate legislation to permit the operation of a Blue Cross plan, is the December report of the Greenville County Hospital Benefit Association. The organization is comparatively small, necessarily so, in view of the act under which it was organized. It has contracts with hospitals in Greenville and naturally operates largely within that county.

While it does not and cannot furnish the benefits common to the usual Blue Cross plan, it follows the group method of enrollment and, most important, is a non-profit corporation — the only such corporation furnishing hospitalization benefits existing in the state at this time so far as we can learn.

According to the report of J. W. Gray, Executive Secretary, members of the Greenville Association received hospital services during September costing \$2,609.51, bringing the total value of hospitalization provided by the Association to \$45,668.96. In October, services valued at \$1,735.05 were furnished. Through the month of October, the organization reported a total enrollment of 8,103 persons in 166 groups. According to the report of the Secretary, the total cost to members has been at an established rate of less than 1½¢ per day.

The bill now before the legislature will, of course, not interfere in any way with the Greenville County Association.

FIFTH DISTRICT MEETING

On Wednesday afternoon, January 17, we had the pleasure of joining the Fifth District Society in its annual meeting which was held at the Meade Villa, 2 miles north of Wimsboro. Leaving Florence immediately after lunch, we were delayed somewhat by car trouble on the way and did not arrive for the opening of the meeting at the appointed hour, 4:00 o'clock. We were in time, however, to hear the closing part of the discussion of a most interesting paper by Dr. Chapman Milling on the effect of shock-therapy in certain cases. Following an interesting paper on certain types of obstetrical cases by Dr. Hart of Columbia, we were given an opportunity to discuss the Ten Point Program.

Your Director, as usual, consumed most of the time (Dr. Price having made it clear on more than one occasion that henceforth he intends to be seen and not heard). Dr. Price did, however, contribute an important part of the discussion in his remarks on the general plan of our activities and the necessity for cooperation.

Our reception was most cordial and we are satisfied of the sympathetic understanding by the doctors who were present of the efforts now being made. Among those present were Dr. Wallace, President of the State Association and Dr. Patterson, President of the State Hospital Association, this being their district meeting. Also present, of course, was Dr. Roderick McDonald, Fifth District Councilor.

Following the business and scientific session, we enjoyed a delicious steak dinner which brought the meeting to a close about 7:30 o'clock.

NEWS ITEMS

Lt. Comdr. Keitt Smith (Greenville) is now stationed at the Naval Hospital at Charleston.

Dr. J. B. Workman (Columbia) has been promoted to the rank of Major.

Dr. J. Warren White, Greenville, has been elected a member of the Southern Surgical Association.

At the first state conference for cancer control ever held in this state the Anderson County Chapter of the Women's Field Army for the Control of Cancer was presented a silver loving cup. The award was made to the chapter for having raised the largest amount of money in the state wide cancer fund campaign.

The Chester County Medical Society has elected the following officers for 1945: President, Dr. Robert D. Hicks; Vice President, Dr. W. J. Henry, Secretary-Treasurer, Dr. V. P. Patterson.

News has been received of the marriage of Miss Oney Fowler of Laurens and Columbia and Dr. W. E. Fulmer of Columbia. Dr. Fulmer has practiced medicine in Columbia for several years.

The following officers were elected at the December meeting of the Anderson County Medical Society: Dr. E. R. Mason, Anderson, president; Dr. W. M. McIlwain, Belton, vice president; Dr. Ned Camp, Anderson, secretary-treasurer.

Dr. W. A. Black of Beaufort was elected President of the First District Medical Society, at its annual meeting in December. Other officers elected were Dr. Pinckney Ryan of Ridgeland, Vice-President, and Dr. A. R. Johnston of St. George, Secretary-Treasurer.

Emory University is sponsoring an ophthalmological Seminar honoring the memory of Dr. Abner Wellborn Calhoun, first professor of ophthalmology at Emory and a pioneer in Southern Ophthalmology. The program will begin on April 19th and go through April 21st, 1945. All those interested in ophthalmology are invited to attend as guests of Emory University.

Captain Robert B. Stith, Jr., arrived in South Carolina on Christmas day for a thirty day leave. Captain Stith had been overseas two and a half years. Before entering the Army he was associated with Dr. W. R. Mead of Florence.

PUBLIC HEALTH NEWS

ENLIGHTENING FIGURES ON SYPHILIS IN SOUTH CAROLINA

More than 20,400 new cases of syphilis were reported in South Carolina in the last fiscal year (1943-44).

At this rate, 1 per cent of the population is acquiring syphilis every twelve months, and if continued at the same rate one half of the population will be infected 50 years from now.

Of the 4600 patients now under treatment in the State Mental Hospital, 32 per cent of the colored males have syphilis; 20 per cent of the colored females have syphilis; 8 per cent of the white males have syphilis; and 10 per cent of the white females have syphilis.

Estimates show that the annual cost per patient to the taxpayers is \$500. Assuming on this basis that 10 per cent of the hospital's patients have been admitted because of mental diseases caused by untreated syphilis, the annual cost to the taxpayers for treatment of these patients is \$230,000.

With such figures before us, it is hard to understand how anybody could object to the amount, however large, spent for venereal disease control.

SOUTH CAROLINA AND FLORIDA STATE BOARD OF HEALTH OFFICIALS CONFER

Officials of the South Carolina and Florida State Boards of Health met at the offices of the S. C. State Board of Health Wednesday morning, January 3, for a discussion of statewide plans for the adequate distribution of health services. During the discussions ideas were exchanged on the approach to certain health problems peculiar to both South Carolina and Florida.

Participating in the conferences were Dr. Ben F. Wyman, State Health Officer; Dr. H. Grady Callison, Director of the Division of Rural Sanitation; Dr. G. E. McDaniel, Director of the Division of Preventable Diseases; Dr. Hilla Sheriff, Director of the Division of Maternal and Child Health; and the three directors of the corresponding divisions of the Florida State Board of Health, i. e., Dr. George A. Dame, Dr. E. F. Hoffman and Dr. Lucille J. Marsh.

South Carolina is one of several Southern States being visited by the Florida health officials.

NEARLY TWO MILLION SPENT BY STATE BOARD OF HEALTH IN 1943-44

Comprehensive Report Gives Expenditures In Detail

The annual report of the State Board of Health for the fiscal year 1943-44 shows in detail, perhaps for the first time since the State Board of Health

was organized in 1878, the expenditures of all funds, totaling \$1,704,836.81.

The largest single expenditure was for Rural Sanitation and County Health Work, with a total of \$762,248.33, while the smallest was that of the Executive Committee, including salaries, per diem and travel, with a total of \$2,383.32. Other expenditures ranged from \$247,507.84 for the Emergency Maternal and Infant Care Program to \$4,689.34 for the Merit System.

Other items included in the report follow: Superintendence and Accounts \$65,810.49; Vital Statistics \$57,556.05; Hygienic Laboratory \$46,899.69; Preventable Disease \$51,507.24; Dental Health \$25,950.98; Industrial Hygiene \$14,596.61; Venereal Disease \$194,276.12; Cancer Control \$16,114.76; Maternal and Child Health \$62,214.28; Training \$11,901.82; Crippled Children \$142,179.94.

The VD Hospitals and the Tuberculosis Sanatorium are not included.

DR. HILLA SHERIFF ELECTED TO NATIONAL COMMITTEE ON MATERNAL AND CHILD HEALTH

Dr. Hilla Sheriff, Director of the Division of Maternal and Child Health, has been elected a member of the Executive Committee of the Association of Maternal and Child Health Directors. She will represent the Southeastern region of the United States for a period of two years.

The Committee is comprised of the Association's president, secretary and treasurer, and four members elected by the Association to represent the country's four geographical regions. Two of the regional members are elected for a period of two years and two for a period of one year.

FROM HAND TO MOUTH

Much is being done by public health and educational agencies to make restaurant patrons and employees cleanliness-minded. Movies, demonstrations, posters, newspaper publicity, and public ratings for sanitation are among the methods used.

One of the recent aids in this field is the extremely interesting booklet of the U. S. Public Health Service, FROM HAND TO MOUTH. This should be required reading for every restaurant worker from the Big Boss to the Bus Boy. It is full of information conveyed so merrily that it makes pleasant reading as well as sound instruction. Its text is summarized by Five C's — Cleanliness, Courtesy, Carefulness, Common sense, and Compliance with the law.

JOIN THE MARCH OF DIMES' PARADE!

AERO SAKOS

When this column begins to write about the Ministers it has really done a "do." However, that is our aim today and since I was "caught" between two ministers at a recent social occasion, I believe I am qualified to write.

One of the stories concerns the church. It seems that a rather definite "reprobate" had been convinced by his wife that he should join the church. He agreed and on the following Sunday was asked by the Minister if he would quit his many un-church like activities. He promised that he would and upon a vote of the church was accepted. While he was riding home he noticed that his wife was crying and questioning her, the husband was told that she could not believe the many things he had promised to stop would really take place. The husband then admitted that in all probability he wouldn't keep his vows to the Church and that if it would make her any happier he would tell the minister the following Sunday. This was done and the Church immediately cast him out. His sage remark went something like this: "The church can't be so hot, I tell lies and they take me in, I tell the truth and they throw me out."

While it didn't happen to our minister, I like to tell the following story about him. It seems that the preacher's evening discourse was dry and long. Members of the congregation began to fade away and out of the church. Finally the sexton tip-toed up to the pulpit and slipped the following note under the corner of the Bible, "When you are through, will you please turn off the lights, lock the door and put the key under the mat?" Our minister isn't the type that will use three words when one will do.

Another story that seems possible is the one told on the minister who went into a saloon and asked for a glass of milk. By mistake he was served milk punch. After drinking it he was seen to glance Heavenward and exclaim, "O LORD, what a cow."

Of course, the average layman cannot get "gay"

with the ministers since many of them have a heavy verbal barrage that they can throw with a great deal of effectiveness. I introduced a minister whom I stated once needed a job rather badly. He was a teacher and was being interviewed for the job by the superintendent of schools. He was asked the question, "Is the world round or flat?" His answer was, as he took the position, "I need this job so badly, I'll teach it either way!" When I sat down the minister dryly remarked that he could understand why the Biblical phrase "Killing the task-master" should be changed to "killing the toast-master."

There is one dog story that Roland Zeigler tells that we can print. I have always thought that sooner or later he would tell a printable story and with him this column goes to the dogs. It seems that a group of men were going bird hunting. They gathered at a small home to wait for the local guide who presently appeared and told them to leave the dogs in the yard since they wouldn't be needed. The hunters finally acquiesced and the hunt was on. The guide would not only point out covey after covey, but also picked up the singles. After a wonderful hunt the group was off to return again two years later. They drove up to the house and a young boy appeared. When asked about his father, he replied that he was dead. "Yep, paw got to running rabbits and we had to shoot him."

BIRTH ANNOUNCEMENTS

Dr. and Mrs. "Pete" Tuten announce the arrival of a daughter, born December 3, 1944. Dr. Tuten is Resident Surgeon at the Columbia Hospital, and is the son of Dr. W. R. Tuten, Fairfax.

Dr. and Mrs. M. Nachman of Greenville are the proud parents of a baby girl, born December 4, 1944.

Dr. and Mrs. James B. Watson of Columbia announce the arrival of a daughter.

Dr. and Mrs. Kirby D. Shealy of Columbia are to be congratulated upon the arrival of a son on November 3, 1944.

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DR. CHAPMAN J. MILLING, Medical Director

Pathological Conference, Medical College of the State of South Carolina

KENNETH M. LYNCH, M.D., PROFESSOR OF PATHOLOGY

ABSTRACT NO. 438

History: The patient, a 32 year old colored woman, was admitted 7-13 with complaint of "Sharp, shooting pains in the bottom of my stomach" — duration three days. This pain had begun in the LLQ radiating to the RLQ and above the symphysis. At first, it was dull and aching in character, but later increased in severity, became sharp and stabbing in character, and caused nausea. LMP 7-3, lasting four days. No history of missed periods. No menstrual irregularities, menorrhagia, metrorrhagia, amenorrhea, nor dysmenorrhea. G. C. infection one year prior to hospitalization with dysuria and leucorrhea. No treatment at that time.

Physical Examination: T. 102°, P. 160. R. 58, B. P. 110/68. Acute ill colored woman, apparently in severe pain, sweating freely, with cold extremities. Bilateral inguinal lymph node enlargement with some tenderness. Lungs clear to P & A. Respiratory rate increased. Heart not enlarged. Rate rapid. No murmurs; sinus rhythm. Abdomen flat; increased muscle tone over entire abdomen. Pain aggravated by light palpation over right and left lower quadrants and over symphysis. No masses or organs palpated. Leucorrheal discharge. Hypertrophied labia minora. Vaginal examination: Elephantiasis of left labia minora. There is induration and thickening of the vaginal

mucosa. Uterus is completely fixed with several firm, smooth masses. There is marked tenderness in the left adnexa with displacement of uterus to right. Thickening of the rectum.

Laboratory Examination:

Urinalysis (cath): Sp. Gr. 1.020, albumin 4 plus, WBC 16/HPF, RBC 2-3/HPF, casts 2 plus F. gran, 2 plus C. gran, 1 plus hyaline.

Blood Count: 20,150 WBC, hgb. 8.5 gms. polys 84%, lymphs 14%, monos. 1%, eos. 1%.

Course: Patient continued to complain of pain. Vomited several times. Became irrational. Abdomen distended on 7-14. Rapid downhill course. Died 7-15.

Dr. John Settle (Conducting): Mr. Adickes, please give us your analysis of this case.

Student Adickes: I was unable to make a definite diagnosis, but considered a number of things. First of all some intestinal crisis, such as rupture of the appendix or of a diverticulum of the colon, must be eliminated. Unless the appendix was abnormal in its position, it does not seem that the symptomatology is fitting. Diverticulitis with rupture is a good possibility, and I cannot entirely eliminate it.

Rupture of an ectopic pregnancy is the next complication to be ruled out. The menstrual history is not in line, but this information is notoriously unreliable. I believe, however, that without a history

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of amenorrhea together with some other inconsistent findings, that I can rule it out. It should begin as a dull pain, following by a feeling of faintness or actual fainting. Vaginal bleeding usually follows in two or three days as the decidua is cast off from the endometrium. The signs of sepsis including the elevated temperature are more severe than is usually the case, and the hemoglobin, although low, is not as depleted as I would expect in a patient dying from hemorrhage.

A twisted ovarian usually manifests itself as a sudden acute pain followed immediately by vomiting.

Dr. Settle: Fixation of the pelvic structures is also against the torsion of a cyst. What else should be included in the differential diagnosis?

Student Adickes: Rupture of a pyosalpinx with formation of a pelvic abscess and then rupture into the peritoneal cavity, might easily explain this picture. Mesenteric thrombosis is not likely. There is no mention of bloody stools, and the lack of a precipitating factor such as arteriosclerosis is against it. Carcinoma of the rectum with ulceration through into the peritoneal cavity must be mentioned, but there is no history to support this.

Dr. Settle: Mr. Carter, do you have anything to add?

Student Carter: One additional point against a ruptured ectopic is that this condition usually causes unilateral pain. The history of gonorrhea, sterility, and fixation of pelvic structures points to an extensive gonorrheal infection, so that rupture of a pelvic abscess seems most likely. The nodules that were felt were probably fibromyomata and probably had nothing to do with the patient's illness.

Dr. Settle: Mr. Connor, what is one of the most common causes of enlargement of the labia?

Student Connor: A Bartholin cyst.

Dr. Settle: That is a localized tumefaction. This condition was general. Mr. Jennings, do you know of any condition that might cause this?

Student Jennings: Lymphogranuloma venereum frequently causes enlargement of the external genitalia, and may extend to involve all the pelvic organs and even produce a peritonitis. The inguinal lymph node enlargement is also common in this disease.

Dr. Kredel: I think an infected abortion must always be considered in this type of case. Thrombophlebitis with septic infarcts to lungs might account for the extreme toxicity and rapid downhill course. The fulminating nature of the peritonitis suggests that the bowel was in some way involved and produced soiling of the peritoneal cavity.

Dr. Pratt-Thomas: The final pathological diagnosis is: *Rectal Stricture due to lymphogranuloma venereum (lymphopathia venereum) with fistulae, perforation, pelvic abscess and generalized peritonitis.*

This case was chosen for presentation with full realization that the patient was practically moribund on admission and that the attending physicians were handicapped by this as well as by the fact that she was in the hospital for only two days. We wished to have you discuss a gynecological problem and also to point out a lesson.

At necropsy besides the enlarged inguinal lymph nodes and hypertrophied labia, there were multiple scars in the inguinal regions, polypoid anal tabs, and a very extensive rectal stricture. Students and phy-

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sicians do not like to examine feces, thereby frequently missing important diagnostic points, such as the finding of amebas in cases of amebiasis. They also are hesitant about performing rectal examinations, although the importance of this is frequently stressed by many of your teachers here. If that examination had been done and recorded, it is likely that the diagnosis might have been more readily made.

Rectal strictures are the most important compli-

cations of lymphogranuloma. Sinus formation is frequent and they may penetrate to the skin surface, about the rectum with formation of perirectal or retroperitoneal abscesses, or break through into the peritoneal cavity. A thrombophlebitis of the hemorrhoidal veins with emboli to the liver with abscess formation may also occur. Lymphogranuloma may involve other organs beside the pelvic structures and there is increasing evidence that it is occasionally a generalized systemic disease.

BOOK REVIEWS

CONTROL OF PAIN IN CHILDBIRTH

By Clifford B. Lull and Robert A. Hingson
J. B. Lippincott Co., Philadelphia

This book is truly the last word in obstetrical analgesia, anesthesia, and amnesia, covering each and every method used for the relief of obstetrical pain that has been developed from the time of Simpson's introduction of chloroform to the most recently advanced methods of spinal and caudal analgesia. Each method of relieving the pain of labor and delivery is covered in detail as to its proper administration, indications, and contra-indications, and comparisons are made with the various other methods of analgesia as regards efficacy, ease of administration, and the practical considerations of availability of the method under discussion.

A most refreshing view-point is the stressing of the fact that there is no one and only form of obstetrical analgesia. To encapsulate the authors' view-point—the form of analgesia and anesthesia must be adapted to the patient as an individual and to the given environment in which the accouchment is being conducted. Thus caudal analgesia may be ideally suited to one individual under the optimum conditions of a well-regulated hospital, while a combination of the sedative analgesics and terminal general anesthesia would be indicated for another individual in labor in the same professional environment. Furthermore, the patient who for various reasons has decided to be confined in the home need not be denied surcease from her travail when the volatile anesthetics can be so easily and safely administered by the open-drop method.

Perhaps the most outstanding departure of the book from the stereotyped handling of the subject of anesthesia is its approach to the subject from an anatomical basis. The anatomical pathways for pain in labor and during delivery are minutely expounded, and thereby is the physiology of such pain and its control by applied anesthesiology the more clearly understood.

In my opinion this book is a must for *all* who attend patients in childbirth, be they specialist or family physician. The specialist will find a wealth of material to broaden his acquaintance with the intricacies of anesthesiological rationale, and come to choose the anesthesia for a given parturient as does

the surgeon for a given operative case. While the family physician (who attends by far the greater number of deliveries in the United States) will be encouraged to proffer to his patients adequate analgesia in labor and during delivery.

P. G. E.

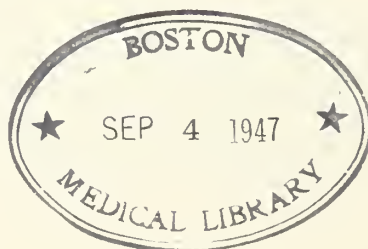
INDUSTRIAL OPHTHALMOLOGY

By Hedwig S. Kuhn, M.D.

First Edition. 294 Pages With 114 Text Illustrations Including 2 Color Plates. Published by the C. V. Mosby Co., 1944. \$6.50

This book is, in reality, an introduction for the ophthalmologist to industry and its visual problems. Its illustrations and text strive to point out the many types of machinery used in industry, each with its separate visual requirement. As the author states, "We cannot understand what to do, visually speaking, with the man carefully using a caliper for exact measurement, unless we know exactly what he is doing. Nor, can we make an estimate for the height of the segment in the bifocal required by the operator of the cutting machine, unless we realize he cuts across the width of the entire table." Eye protection is well covered with an enumeration and description of goggles and other mechanical devices. Also, the more recent developments relating to industry, as welding and radiation, and their effects on eyes are discussed. An up-to-date summary of epidemic keratoconjunctivitis, with two color plates for illustration, is included as one disease that confronts the industrial ophthalmologist. The appendix contains three valuable items that will be constantly referred to by anyone having industrial practice. These subjects are 1.) Toxic hazards with a glossary of toxic substances and their effect; 2.) A check list for outlining a program for industry; 3.) Appraisal of loss of visual acuity and the standard method employed by the Section on Ophthalmology of the A. M. A. Dr. Kuhn is well qualified to write this book and she has presented the material attractively. There is a chapter on "Industrial Eye Injuries Caused by Solid Bodies" by Albert C. Snell, M.D., who, besides describing the treatment and diagnosis of such, brings in the economical aspects of these injuries in industry.

G. S.



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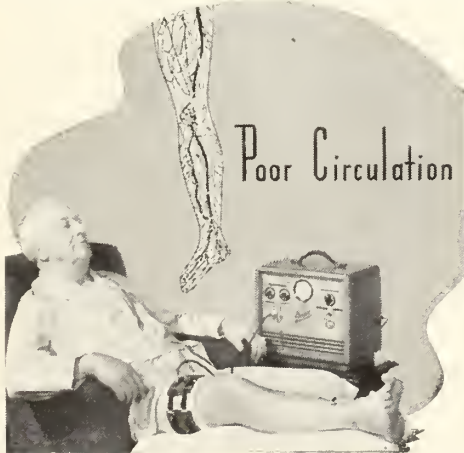
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FROM WASHINGTON

Herewith we are sending you a list of some of the bills which have been introduced into the 79th Congress. In later bulletins we shall continue to report the bills as they are introduced. If you are particularly interested in any bill and especially if your congressman is the author of any, write to him for a copy, designating it by its number. Your congressman will appreciate the interest you show and it is a good public relations act to begin your correspondence with your congressman before you need write him to oppose other congressmen's bills.

H. R. 1 by Mr. Ludlow of Indiana.

A Bill to Provide Disability Benefits for Honorably Discharged Veterans Under Certain Circumstances.

Referred to the Committee on World War Veterans' Legislation.

Comment: Provides that any inductee who shall make a statement at the time that he is inducted that he has a definite pathology, or if such pathology is discovered at the time he is examined and he is nevertheless inducted and later, after serving, such pathology shall develop into a disability and it becomes necessary to discharge him, the said ailment or disability shall be assumed to have been aggravated by service.

H. R. 56 by Mr. Izac of California.

A Bill to Amend Section 1001, title X, of the Social Security Act, to Include Needy Individuals Who Are Permanently Crippled.

Referred to the Committee on Ways and Means.

Comment: Provides that the blind shall be considered permanently crippled in interpreting the Social Security Act and entitled to all the benefits given to a permanently crippled or disabled person.

H. R. 103 by Mr. Voorhis of California.

A Bill to Grant Permanent and Total Disability Ratings to Veterans Suffering from Severe Industrial Inadaptability as a Result of War Service.

Referred to the Committee on World War Veterans' Legislation.

Comment: Provides that where a disability suffered by a veteran while in service results in producing a severe industrial inadaptability, interfering with his being employed or with his following continuously any gainful occupation, that veteran shall be considered as permanently and totally disabled.

H. H. 140 by Mr. Voorhis of California.

A Bill to Amend the Social Security Act, and for Other Purposes.

Referred to the Committee on Ways and Means.

Comment: Provides for the amendment of the Social Security Act so as to make each State its own authority in interpreting the phrases "needy individuals." The Federal Government shall not object to the interpretation of the State nor refuse to cooperate with the State's program by denying it its proportionate share of subsidy because of a difference in the interpretation of this and other

phrases.

H. R. 141 by Mr. Voorhis of California.

A Bill to Amend the Social Security Act, and for Other Purposes.

Referred to the Committee on Ways and Means.

Comment: Here Mr. Voorhis takes a position similar to the one in the preceding bill; that is, that the State shall be the sole authority in determining the interpretation of such phrases as "needy individuals who are blind" and "blind individuals who are needy." The Federal Government shall not object to paying its share of the subsidy to that State because of a difference of opinion.

H. R. 151 by Mr. Voorhis of California.

A Bill to Establish More Equitable Procedure Governing the Determination of Service Connection of Diseases or Injuries Alleged to Have Been Incurred in or Aggravated by Active Service in a War, Campaign, or Expedition.

Referred to the Committee on World War Veterans' Legislation.

Comment: Provides that the veteran who has a disability which can be traced to his period of service has the right to have that disability considered as due to or aggravated by such service in line of duty.

H. R. 284 by Mr. Randolph of West Virginia.

A Bill to Provide for Health Programs for Health Programs for Government Employees.

Referred to the Committee on the Civil Service.

Comment: Provides medical facilities for all Federal employees. There is already established some facility of this kind for certain departments, but Mr. Randolph would like to see it extended to cover all Federal employees. The services are to be established only upon recommendation by the Civil Service Commission after consulting with the Public Health Service and are to be limited to: (1) Treatments of minor illnesses and dental conditions, except in cases of emergency; (2) Pre-employment and other examinations; (3) Referral of employees to private physicians and dentists; (4) Education and preventive programs relating to health, including alleviating of health hazards in the working environment.

H. R. 327 by Mrs. Rogers of Massachusetts.

A Bill to Provide for the Establishment of a Permanent Nurse Corps in the Veterans Administration.

Referred to the Committee on World War Veterans' Legislation.

Comment: Provides for the establishment in the Veterans Administration of a permanent Nurse Corps to be known as the Veterans Administration Nurse Corps and hereinafter referred to as the Nurse Corps. The officers of the Corps shall consist of one Superintendent of Nurses, with the rank of Colonel, to be appointed by the President, and 16,000 officers.

H. R. 395 by Mr. Dingell of Michigan.

A Bill to Provide for Public Health Insurance. Referred to the Committee on Ways and Means.

Comment: This is the 1944 bill. Mr. Dingell announces that he is engaged in drafting some amendments to this bill which he will introduce later.

H. R. 491 by Mr. Lemke of North Dakota.

A Bill to Prohibit Experiments Upon Living Dogs in the District of Columbia and Providing a Penalty for Violation Thereof.

Referred to the Committee on the District of Columbia.

Comment: Mr. Lemke introduced an anti-vivisection bill to apply only in the District of Columbia but the proponents of this bill, we know very well, consider that if Congress enacts it for the District of Columbia they will have thereby gained a great point in having a similar law enacted in the various states.

H. R. 519 by Mr. Mundt of South Dakota.

A Bill to Prevent Pollution of the Waters of the United States and to Correct Existing Water Pollution as a Vital Necessity to Public Health, Economic Welfare, Healthful Recreation, Navigation, the Support of Invaluable Aquatic Life, and as a Logical and Desirable Post-War Public-Works Program.

Referred to the Committee on Rivers and Harbors.

Comment: Provides for a National Board of Water Pollution Control. Mr. Mundt feels that many streams are unnecessarily polluted. In many instances the pollution is a health hazard. Other communities lower down the stream frequently take the water for their drinking purposes. He feels that every community should be obliged to provide facilities for disposing of its pollution rather than emptying it into the flowing streams.

H. R. 525 by Mrs. Norton of New Jersey.

A Bill to Provide for Cooperation with State Agencies Administering Labor Laws in Establishing and Maintaining Safe and Proper Working Conditions in Industry and in the Preparation, Promulgation, and Enforcement of Regulations to Control Industrial Health Hazards Referred to the Committee on Labor.

Comment: Provides for the authorization of the Department of Labor "to cooperate with State agencies administering labor laws in establishing and maintaining safe and proper working conditions in industry and in the preparation, promulgation and enforcement of regulations to control industrial health hazards." A sum of \$5,000,000 is asked to finance the work. I am informed that in most States the working conditions in industries are a responsibility of the Health Department. Two states, however, New York and Massachusetts, have such juris-

diction a part of the function of the Department of Labor. Mrs. Norton carried a similar bill last year.

H. R. 535 by Mr. Peterson of Florida.

A Bill to Define Loss of Use of an Eye for the Purposes of Granting the Statutory Award of \$35 per Month Under the Provisions of Subparagraph (k), Paragraph II, Part I, Veterans Regulation Numbered 1, (a), as amended.

Referred to the Committee on World War Veterans' Legislation.

Comment: "For the purposes of this subparagraph the use of an eye shall be considered lost when visual acuity is 5/200 or less."

H. R. 567 by Mr. Rankin of Mississippi.

A Bill to Extend Eligibility for Compensation to the Widows and Children of World War Veterans Who Had Disabilities Caused or Aggravated by Examination, Hospitalization, or Medical Treatment.

Referred to the Committee on World War Veterans' Legislation.

Comment: If the veteran was, at the time of his death, entitled to or in receipt of monetary benefits then his widow and children shall be eligible for compensation.

H. R. 569 by Mr. Rankin of Mississippi.

A Bill to Provide Compensation or Pension for the Widows and Children of Deceased Veterans of World War I or World War II Who Had Disabilities Caused or Aggravated by Examination, Hospitalization, or Medical Treatment.

Referred to the Committee on World War Veterans' Legislation.

Comment: Herein Mr. Rankin specifically states that if the veteran is a veteran of World War I or World War II and dies while entitled to or in receipt of monetary benefit his widow and children shall be eligible for benefits.

H. R. 584 by Mrs. Rogers of Massachusetts.

A Bill to Provide Permanent and Total Disability Rating in Active Pulmonary Tuberculosis Cases.

Referred to the Committee on World War Veterans' Legislation.

Comment: The bill reads thus: "That notwithstanding any provision of law or Veterans Regulations, any World War ex-serviceman shown to have active pulmonary tuberculosis of compensable degree shall be deemed to be totally disabled for purposes of compensation when hospitalized."

Respectfully submitted,

Joseph S. Lawrence, M.D., Director

Council on Medical Service and

Public Relations.

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The Journal of the South Carolina Medical Association

MARCH, 1945

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1. Am. J. Dis. Child. 66:1 (July) 1943.



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March, 1945

NUMBER 3

Treatment of Tetanus With Tetanus Antitoxin and Penicillin

J. M. ALBERGOTTI, JR., M.D., ORANGEBURG, S. C.

In the past three years there have been admitted to my service in the Tri-County Hospital eight cases of tetanus. Five have recovered, three have died. One death was that of a seven day old infant, delivered by a mid-wife, moribund on admission, umbilical stump infected, death occurring within twelve hours. A second death occurred as a direct result of unfortunate intravenous administration of tetanus antitoxin, 40,000 units, by a new hospital employee too rapidly and without dilution despite a service rule against such. Convulsions and death occurred within thirty minutes after serum administration. Skin and conjunctival tests had been negative. The third death was not marked by any unusual circumstances. Seven were colored, seven male, and all were under ten years of age. With the exception of the presently reported case, severe suffering, dangerous, tedious treatment and laborious convalescence attended each recovery. Large doses of antitoxin were administered to seven of the eight cases, dosage ranging up to 360,000 units, most of it given in first 48 hours. In no case save one was the antitoxin administered after the first 48 hours. Antitoxin was given intravenously in each case an hour after an initial intramuscular injection, usually around the site of the wound. In four of five recoveries avertin was administered in doses of 60 mg. per kg., often enough to keep the patient almost fully anesthetized, except in this last case when it was apparent that it was unnecessary. No antitoxin was given intrathecally.

Reported mortality ranges between 30 and 90%. No conclusions can be drawn in this respect from eight cases. It was not possible to draw conclusions, either, about the relationship of a short incubation period and severity of course, as no portal of entry could be found in three cases. The histories were unreliable also.

Case Report: C. W., male, colored, age 9 years, admitted noon, 7-29-44, apparently seriously ill.

History: A nail puncture wound of dorsum of

The Author:

A graduate of the University of Pennsylvania School of Medicine, (1933), Dr. Albergotti is located in Orangeburg and limits his practice to diseases of children.

right foot occurred near barnyard of home on 7-22-44, untreated, and followed by no symptoms for five days, until 7-27-44, when he became ill with low-grade fever, pains in abdomen and extremities, which rapidly developed into cramps, headache, difficulty in chewing and swallowing. Inability to open jaws was not noted until the second day. Pain, hyper-irritability, increasing stiffness of the neck, inability to eat, trismus, fixed smile, the risus sardonius so frequently described, the appearance of generalized painful convulsive seizures were present by the evening of the second day. Parents stated that noise or movement made him worse. Subjectively the outstanding symptoms on the third day, or day of admission, were pain on any disturbance, and a sense of suffocation.

On examination, patient was a mulatto, apparent age same as stated, 9 years, apparently very ill. Facial expression typical of fixed muscular spasm or tonic contracture. Flaring of alae nasae on inspiration. Jaws could only be opened a quarter of an inch voluntarily, perhaps an eighth more with a tongue depressor. Throat could not be seen. Stiff neck very marked. Respirations were 20 per minute, shallow. Abdominal examination revealed a board-like rigidity, with the recti standing out clearly. Muscles of the extremities were generally rigid, the biceps and gastrocnemius being particularly noticeable. Examination was a painful process, movement increasing the muscle spasm remarkably. Consciousness was complete throughout. Rectal temperature on admission 100.2, pulse 88/ minute. Child was unable to speak intelligibly, could mumble. There was a dirt-filled puncture wound of the right

foot, without apparent inflammatory reaction. The opening of the wound was about 2 mm. in diameter. It was subsequently proved to penetrate approximately 1/2 inch into the foot. There were no streaks or traceable paths of tenderness up the foot or leg. Glands in inguinal region were not more noticeably enlarged than the ones in the other groin.

Treatment and Progress

7-29-44 12:00 Noon: Admitted to ward.

12:15 P. M. Intracutaneous test for serum sensitivity. Penicillin 30,000 Florey units intramuscularly.

1:00 P. M. Sodium amytal gr. 2 rectally. Tetanus antitoxin 20,000 units intramuscularly. Drank 6 ounces of Coca-Cola.

2:45 P. M. Adrenalin Chloride minims 5 subcutaneously.

3:05 P. M. Tetanus antitoxin 100,000 units in 300 c. c. of normal saline solution given in one hour.

4:00 P. M. Penicillin 10,000 units intramuscularly. Drank 6 ounces of tea.

5:00 P. M. Sodium amytal gr. 2.

6:00 P. M. Temp. 103.4, pulse 120, resp. 32. Nurse's report: "Condition poor."

8:00 P. M. Penicillin 10,000 units.

9:00 P. M. Sodium amytal. When seen by me at this time child was sleeping soundly on face although placed in a noisy corridor.

7-30-44 12:00 M. Penicillin 10,000 units i. m.

4:00 A. M. Penicillin 10,000 units i. m.

1:00 A. M. to 7:00 A. M. Slept soundly except when awakened for medications.

8:00 A. M. to 9:30 A. M. Took 390 c. c. pineapple juice and water. TPR 99.6-104-24. Voluntarily stated he felt better.

1:00 P. M. Sitting propped on a pillow, spoke intelligible greeting voluntarily. Trismus same, but general muscular spasm markedly decreased. Dysphagia very much less. Subjectively having no pain and suffocative feeling had disappeared. Tetanus antitoxin 40,000 units given intramuscularly.

9:00 P. M. Asleep and slept all night. Penicillin 10,000 units and sodium amytal grs. 2 were continued every four hours.

7-31-44 12:30 P. M. Incision made to base of puncture wound, cleansed of dirt, irrigated with solution containing 250 units of penicillin to 1 c. c. Penicillin 10,000 units injected into tissue around puncture wound.

8-1-44 Penicillin dosage reduced to 5,000 units every four hours.

12:00 Noon TPR 99.4-86-20. No subsequent rise. Able to relish a light diet, sit up in bed, was free of subjective symptoms, sleeping well, trismus still present but able to open mouth an inch. Muscles of extremities relaxed, essentially normal. Disturbance no longer bothered him. Risus sardonicus largely disappeared. Steady improvement continued.

8-4-44 Penicillin and sodium amytal discontinued.

8-7-44 Discharged ambulatory. Only apparent residual a slight persistence of trismus and some stiffness of neck musculature.

Incidental Laboratory Procedure on Admission: Hbg. (Haden-Hauser) 14.0 O. G., W. B. C. 11,400, polys 86, lymphocytes 14; malaria smear no parasites, sedimentation rate 7 mm. in one hour; urine negative except for trace of sugar; Kline negative; feces negative for blood, ova and parasites. Due to oversight, culture was not made from wound. It was not deemed advisable to go into it a second time.

Summary and Conclusions: A case of tetanus, which by all previous experience and by the rapid progress of symptoms and signs after onset, and the very short (5 day) incubation period, augured for a fulminant type of tetanus, was treated by use of penicillin, with tetanus antitoxin used as an adjunctive treatment, subjective and objective improvement following in 24 hours, patient being apparently out of danger in 48 hours, convalescing after this time. Rapid subsidence of pain, muscle spasm, and hyper-irritability was dramatic.

245,000 units of penicillin were administered intramuscularly, 10,000 additional around site of wound in foot, and irrigation of debrided puncture wound with penicillin was done on third day of hospitalization, beginning of fifth day after onset. Tetanus antitoxin 100,000 units was given intravenously, and 60,000 units intramuscularly in first twenty hour hours.

The following facts are well established: Tetanus bacilli and spores do not move from the site of the infection, but produce a rapidly diffusible tetanotoxin, which move along the peripheral nerve filaments and axis cylinders to final fixation in the nerve centers. Toxin fixed by nerve cells cannot be neutralized by antitoxin, the function of antitoxin being to neutralize the tetanotoxin produced but not yet fixed, and perhaps that being produced. It is accepted that in experimental animals, simultaneous injection of tetanotoxin and antitoxin is followed by a more rapid absorption of toxin than of antitoxin. Tetanus antitoxin is not strongly bactericidal, consequently the production of toxin proceeds in the presence of antitoxin, as the infected wound continues to throw out tetanotoxin. It seems logical to assume that early disturbance of the wound would throw into the system more circulating toxin, some of which would proceed to nerve cell fixation, in spite of anti-toxin. The evidence as to the effect of penicillin in this regard is too meager to draw conclusions. It is rational, then, to wait until optimum blood concentration of penicillin is obtained, and adequate doses of antitoxin have been administered before cleansing the wound. The obvious exception is the wound with localized pus which can be evacuated with little tissue interference.

The course of this case suggests that penicillin

may have some beneficial effect on the fixed toxin itself, as evidenced by the rapidity with which the usually persistent signs and symptoms cleared up.

Until the efficacy of penicillin alone in tetanus is determined, the combined penicillin-antitoxin treatment has some merit in comparison with previously accepted treatment.

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The General Surgical Significance of Vasoconstriction*

H. G. SMITHY, M.D., CHARLESTON, S. C.

In a rather wide variety of surgical conditions, peripheral vascular constriction occurs as a contributory or causative agent or coexists as a troublesome complicating factor. The elimination of vasospasm by either temporary or permanent measures contributes much to both the diagnosis and treatment of the underlying diseases. In the following surgical entities, vasospasm is an integral part of the pathologic process, but certain diagnostic and therapeutic ramifications of the diseases are of such significance that individual consideration of each condition is justifiable.

THROMBOPHLEBITIS

In recent years, emphasis has been placed upon the strong element of vasospasm in the presence of acute inflammatory obstruction of the deep veins of the lower extremity.¹ The existence of a femoral inflammatory thrombus initiates reflex vasoconstrictor impulses which are mediated by the sympathetic nervous system. Since reflex impulses of autonomic origin tend to be discharged "en masse," the resulting vascular spasm is widespread in the affected limb and involves veins as well as arteries. By this mechanism, both increased venous pressure and decreased total volume of circulating arterial blood are produced, contributing in a two-fold manner to the resulting tissue hypoxia. Since capillary endothelium rapidly loses its physiological function in an atmosphere of diminished oxygen tension, increased permeability ensues and the development of an edematous extremity quickly becomes established. The distressing sequelae of postphlebotic edema, such as ulceration, intermittent claudication, and a chronically swollen leg, can be prevented effectively by the early interruption of sympathetic nerve impulses to and from the involved extremity. Procaine infiltration of the ipsilateral lumbar sympathetic

From the Department of Surgery of the Medical College of the State of South Carolina.

*Presented before Greenville County Medical Society, Oct. 2, 1944.

The Author:

Dr. Smithy is a graduate of the University of Virginia School of Medicine (1938). He is now connected with the surgical department at Roper Hospital and at the Medical College of the State of S. C.

ganglia results in prompt relief of pain, gradual disappearance of edema and a return of the body temperature to normal. Because of the short duration of the effects of novocaine, daily injections are advocated until the patient has become afebrile. Outstanding, and often dramatic, results are obtained by this method of treatment. Emphasis is placed upon the fact that a cure is most likely to be obtained when treatment is instituted shortly after the onset of symptoms, preferably within the first 72 hours.

POST-TRAUMATIC PAINFUL SYNDROMES

Painful affections of a bizarre and spectacular sort sometimes appear following injury to the extremities. While little is known concerning the mechanism of the disorders, vasomotor disturbances are common to all and constitute a prominent feature of the clinical picture. The three established entities of this group are traumatic vasospasm, causalgia, and Sudeck's atrophy.

Traumatic Vasospasm—Following direct injury to a large artery, constriction of the affected vessel and its distal branches results. In the presence of a severe laceration or complete division of an arterial trunk, this protective constrictor mechanism sometimes is sufficiently effective to prevent death from hemorrhage. In other instances, however, the spastic factor becomes a detrimental reaction and constitutes the condition known as traumatic vasospasm.² Crushing injuries of an extremity without disruption of the arterial tree, bullet wounds near a main artery of the arm or leg, or less significant degrees

of trauma to a limb can initiate a generalized arteriospasm of the entire appendage. Clinically, the phenomenon manifests itself primarily by pronounced decrease in surface temperature at the site of and distal to the injury. The peripheral pulses of the injured member become greatly reduced in volume and often are impalpable. Once established, the syndrome follows a variable course. The clinical signs sometimes spontaneously disappear after a few hours or days, while progression of the disorder to complete gangrene rarely may occur. Occasionally, coldness and bluish-white discolorations of the skin persist for months without gangrene and functional impairment becomes pronounced. When the syndrome is seen early, procaine injection of the corresponding sympathetic ganglia will produce prompt restoration of blood flow and disappearance of clinical signs. One novocaine block is permanently effective in a surprisingly high percentage of cases, while repeated injections may be necessary to prevent recurrences of the vasospasm in a few instances. The cold, functionally impaired limb which has persisted for some time without gangrene usually can be returned to normal only by surgical removal of the regional sympathetic ganglia, novocaine block being of only temporary benefit in most long-standing cases.

Causalgia — The perplexing syndrome described by Weir Mitchell, consisting principally of burning pain, cold moist skin and late trophic changes in the nails, occurs following an injury near a major nerve trunk of the arm or leg. While the disorder presents some features of autonomic nervous hyperactivity, it frequently embodies other characteristics which are not easily interpreted. Vasospasm is not an integral part of every case of causalgia. For this reason, sympathetic novocaine block becomes especially valuable as a diagnostic measure in classifying causalgia patients according to treatment. When temporary relief from ganglion infiltration is well-defined, surgical sympathectomy is usually of permanent benefit. When relief from the intense hyperesthesia fails to follow sympathetic block after repeated trials, little can be expected from sympathectomy. Although causalgia appears to be related closely to traumatic vasospasm in its mode of production, the percentage of patients responding favorably to the interruption of sympathetic impulses is unfortunately low.

Sudeck's Atrophy — Injury to an extremity near a multi-articular joint, such as the carpus or tarsus, may initiate a baffling vasomotor disorder, first described by Sudeck³ in 1900. Characteristically, unlocalized radiating pain in the injured limb is the outstanding feature of the disease and manifests itself as a burning, smarting and tingling sensation. Its intensity is great and frequently is far out of proportion to the degree of initial trauma, which usually is slight. Two other clinical features establish the diagnosis: early onset of severe and progressive decalcification of the affected tarsal or car-

pal bones and the adjacent metatarsals or metacarpals, and subsequent changes in the skin consisting of alternating cyanosis and blanching, subjective and objective coldness and a shiny or glossy appearance of the cutaneous surface. No explanation of the extraordinary sequence of events in Sudeck's atrophy is adequate but the factor of sympathetic nervous hyperactivity seems well-established by virtue of the prominence of vasomotor disturbances in the clinical picture. On this basis, paravertebral novocaine block of the corresponding ganglia has been used with great success in differentiating the malady from malingering and psychogenic states. Response to ganglion block is quite favorable in a high percentage of cases and represents the soundest method of evaluating the likelihood of cure by operative sympathectomy. The latter procedure is the treatment of choice of Sudeck's disease and is followed by good results, including disappearance of the osteoporosis, in properly selected patients.

ACUTE ARTERIAL EMBOLISM

The occurrence of sudden embolic obstruction of a large peripheral artery is followed quickly by profound ischemia of the affected extremity distal to the point of obstruction and is manifested by coldness and pallor of the skin. This situation is not due entirely to the arterial obstruction but is in large measure the result of an associated vasospasm initiated by the embolus. The preservation of a viable extremity under such circumstances is dependent upon prompt restoration of adequate blood flow. In a considerable number of cases this can be done by embolectomy. The time factor, however, is not flexible and unless tissue anoxia is relieved in a short time, gangrene becomes inevitable. To bridge successfully the gap between the onset of embolism and the time of operation, elimination of sympathetic impulses in the affected member by procaine injection of the regional ganglia is of invaluable aid. By this procedure, vasospasm is abolished and immediate improvement in the color and temperature of the appendage occurs. So effective is sympathetic block that embolectomy may be made an elective procedure, allowing time for the administration of adequate anti-coagulant therapy before operation. In embolism with unusually severe ischemia, such as occurs in advanced obliterative arterial disease, viability of the limb can be protected further by combining sympathetic block with ice refrigeration of the ischemic extremity while preparations are being made for operation. The reduction in tissue metabolism incident to mild refrigeration and the elimination of vasospasm by paravertebral ganglion injection effectively reduce the likelihood of gangrene.

The combined effects of refrigeration and procaine sympathetic block can be applied successfully to the postoperative care of patients in whom repair of peripheral aneurysms or ligation of large arterial trunks have been done. This form of treatment is of particular value when the collateral circulation

appears to be poorly developed.

PERIPHERAL VASCULAR DISEASE

Generally speaking, peripheral arterial disease is divided into two groups: functional or vasoconstrictor types, and organic or occlusive varieties. Of the first group, Raynaud's disease and its allied syndrome, hyperhidrosis of nervous origin, constitute the main entities. Both maladies are expressions of intense sympathetic nervous activity embodying severe vasospasm as the underlying factor in the pathologic physiology. The diagnosis is usually quite clear and can be corroborated by paravertebral novocaine block of the appropriate sympathetic nerve trunk. Cure is attained in a very high percentage of cases by sympathectomy.

Of the second group, Buerger's thromboangiitis obliterans and arteriosclerosis are outstanding examples. In Buerger's disease, there is a strong element of vasospasm in the early stages of the affection, although an obliterative process is associated in all cases. When this spastic factor can be demonstrated by skin temperature determinations and oscillometric studies before and after novocaine interruption of the sympathetic impulses, sympathectomy should be done. This attitude toward thromboangiitis obliterans is adopted with the idea in mind of preserving the patient's function for a maximum period of time and prolonging or forestalling the eventual onset of gangrene. Ganglionectomy will not cure Buerger's disease but, if performed during the spastic phase of the disorder, it will postpone amputations for many months and will abolish for long periods the distressing pain.

Arteriosclerosis, the commonest of the peripheral arterial diseases, has been treated in recent years by sympathectomy in an increasing number of cases.⁴ Despite the fact that arteriosclerosis is a disease of arterial occlusion, there are many victims of the disorder whose peripheral arterial bed contains innumerable small arteries and arterioles capable of vasodilatation. On this basis, sympathectomy has been given a fair trial and has proven to be of definite value. Preliminary sympathetic procaine block followed by thermocouple readings of the skin temperature serves as a dependable guide to the degree of vasodilatation which one may expect from sympathectomy.

There are three specific situations in which operative removal of the lumbar ganglionated chain gives the best results in arteriosclerosis: (1) impending gangrene, (2) gangrenous ulceration, and (3) ischemic pain. After sympathectomy, the cold reddish purple foot of the pre-gangrenous state is restored to normal color and temperature and arteriosclerotic ulcers can be made to heal or can be excised safely, leaving a healthy granulating area for skin grafting. The disabling pain of intermittent claudication disappears rapidly after the operation in a high percentage of patients and the distressing rest pain, with or without ulceration, responds similarly. It is now established that lumbar gan-

glinectomy has obviated the need for amputation in a considerable number of arteriosclerotic patients and has restored to normal activity numerous others previously crippled by pain and ulceration.

VARICOSE VEINS

The cure of varicose veins depends upon complete obliteration of the incompetent saphenous venous system. This can be accomplished either by actual removal of the varicosities themselves⁵ or by high ligation of the main saphenous vein and simultaneous retrograde massive sclerosis of the saphenous system by catheter injection of a strong sclerosing agent such as sodium morrhuate. The latter method affords highly satisfactory results but large doses of the sclerosant (as much as 30 cc in each leg) must be used to insure complete obliteration of the veins. Under these circumstances, the post-operative chemical thrombophlebitis is extensive and sometimes gives rise to two complicating factors which respond readily to interruption of the sympathetic impulses by ganglion block with novocaine. The first is severe pain due to the chemical phlebitis and the other is postoperative vasospasm.

Pain in the injected venous trunks is a regular sequela of massive catheterization and sclerosis of varicose veins. In the great majority of instances, the discomfort is reduced to an insignificant degree by bed rest and is virtually always temporary, enduring for only two or three days after operation. In the rare, exceptional case, however, burning, stinging pain persists despite confinement of the patient to his bed. When the discomfort is unduly prolonged or when it occurs in individuals whose pain threshold is abnormally low, paravertebral procaine infiltration of the regional sympathetic trunk is indicated. Pain of vascular origin is relieved effectively by sympathetic block.

On the basis of experimental studies made by De Bakey, Burch, and Ochsner,⁶ in which they demonstrated that a localized chemical endophlebitis of a large peripheral vein causes vasospasm of sufficient degree to reduce materially the peripheral pulsations of the involved extremity, one would expect peripheral vasoconstriction to follow frequently the widespread sclerosis of a varicose saphenous tree. While such a situation actually is quite rare, it does occur and may be alarming to the extent of producing a cold, pulseless extremity whose viability is seriously jeopardized. A complicating factor of such magnitude requires prompt attention and immediate sympathetic block should be done to abolish the vasospasm. When the block has become complete, the skin temperature and peripheral pulse volume are restored to normal.

CEREBRAL THROMBOSIS

Vascular insufficiency of the brain, a common and disabling entity, may result spontaneously from three causes: embolism, arterial hemorrhage after rupture of the vessel walls, and arterial thrombosis. Over half of the cases are due to thrombosis of the middle cerebral artery or one of its component

branches. There is evidence⁷ to indicate that vasospasm, in the presence of cerebral arterial thrombosis, plays an important part in the production of the resulting cerebral ischemia during its early phases. Temporary interruption of the sympathetic impulses to the brain under such circumstances has been shown to have a considerable effect in relieving or preventing hemiplegia.^{7, 8} Occasionally, the results are extraordinary. The greatest benefit from sympathetic block in hemiplegia is obtained in early cases, where the procedure is employed shortly after occurrence of the "stroke." Some good results follow novocaine ganglion injection in late cases, even months after the hemiparesis has become established. In the latter group, it is possible that sympathetic block can be utilized as a therapeutic test in evaluating further treatment. Kredel⁹ has shown that improvement of collateral cerebral circulation after arterial thrombosis may follow a temporal myopexy to the denuded cerebral cortex. He has emphasized the fact that the majority of satisfactory responses to his operation occur in early cases but encouraging results are obtained occasionally in long-standing hemiplegia. Temporary interruption of cerebral sympathetic impulses by novocaine block presents a logical possibility of determining the potential value of brain myopexy in late cases of cerebral thrombosis.

Anatomically, the most convenient location for interruption of sympathetic impulses to the brain is the stellate ganglion. Infiltration of that structure with procaine is accomplished quickly and easily. Successful completion of the block is determined by the appearance within a few minutes of an ipsilateral Horner's syndrome.

TECHNIQUE OF GANGLION BLOCK

Paravertebral Upper Thoracic Block — The outflow of sympathetic fibers from the spinal cord to the sweat glands and blood vessels of the arm travels principally by way of the second and third thoracic ganglia. These two structures, therefore, must be infiltrated completely with novocaine in order to suspend sympathetic activity in the upper limb.

With the patient lying on his side, head flexed on the chest, the spinous processes of the upper dorsal vertebrae are located by palpation. Due to the imbrication of the processes over one another like the shingles of a roof, the tip of each spine represents the level of the vertebra immediately below it. Using the vertebra prominens (the seventh cervical) as a guide, the first and second thoracic spinous processes are located. Hypodermic infiltration of the skin by a few drops of 1% Novocaine is made 3 or 4 cm. lateral to each process. Through the wheals thus produced, an ordinary spinal puncture needle is inserted perpendicular to the skin and is pushed inward until bony contact is made, a depth varying from 3 to 6 cm. Sudden arrest of the needle by bony interference indicates contact with the transverse process. The needle is then inclined first caudad and

then cephalad so as to slide over the inferior and superior margins of the transverse process. At the same time, the needle is directed toward the midline so as to come shortly into contact with the vertebral body after a further progression of about 3 cms. When this contact is made, injection of 3 or 4 cc of 1% novocaine is accomplished both above and below the transverse process. The ganglionated chain hugs closely the antero-lateral portion of the vertebral bodies and is brought into contact with the novocaine by the procedure outlined above. Within fifteen minutes of a successful block, disappearance of sweating and a palpable increase in skin temperature appears in the involved extremity.

Paravertebral Lumbar Block — Unlike the arrangement of the dorsal vertebral structures, the lumbar spinous processes are not imbricated or shingled over one another, but project posteriorly at an angle of 90 degrees to the long axis of the back and trunk. For this reason, location of any given lumbar spinous process marks the level of the transverse process of the same vertebra. With this anatomical relationship in mind, one may infiltrate the lumbar ganglia by the same technique described for upper thoracic paravertebral block. The first, second, third, and fourth ganglia should be injected to insure complete interruption of sympathetic activity in the leg.

Stellate Ganglion Block — The inferior cervical and first thoracic sympathetic ganglia are fused together to constitute the stellate ganglion. It is located, subject to slight variation, between the transverse processes of the seventh cervical and first thoracic vertebrae and is closely adherent to the antero-lateral portion of the junction of the two vertebral bodies. Procaine injection of the stellate ganglion can be accomplished from either an anterior or posterior approach. In the latter case, the patient is placed on his side with the head flexed sharply upon the chest. The prominent spinous process of the seventh cervical vertebra is identified, thus marking the level of the first thoracic transverse process. By the procedures described above, the needle is impinged upon the antero-lateral surface of the vertebral bodies between the spinous processes of the seventh cervical and first thoracic vertebrae. Infiltration of the tissues immediately adjacent to the bodies in this region with 1% novocaine is carried out. Horner's syndrome develops within a few minutes when the block is successful.

For the anterior approach to stellate ganglion block,¹⁰ a point is selected 1 cm. medial to the mid-point of the clavicle. The skin immediately above the superior border of the clavicle at this level is infiltrated with a few drops of novocaine until a wheal is formed. An ordinary spinal puncture needle is introduced through the wheal and is directed posteriorly at an angle of 45 degrees with the median sagittal plane. At a depth of approximately 7 cm. the point of the needle engages the antero-lateral aspect of the junction of the seventh cervical and

first thoracic vertebral bodies. Infiltration of this area with 1% novocaine is then accomplished. Complete block is detected by the development of Horner's syndrome.

SUMMARY

1. The therapeutic and diagnostic significance of the interruption of sympathetic nervous impulses is considered in a number of different diseases.

2. Special consideration is given to recent developments in the treatment of arteriosclerosis by sympathectomy.

3. The technique of novocaine injection of the stellate, upper thoracic and lumbar sympathetic ganglia is described.

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Maternal Mortality Greenville Hospitals 1938-42 Incl.

JACK D. PARKER, GREENVILLE, S. C.

This study covers all obstetrical deaths occurring in the Greenville General and St. Francis Hospitals during the past five years. The statistics presented are derived from 6,413 deliveries.

Prior to the last 2 or 3 years maternal mortality studies were much commoner than at present, and the most popular journals usually published the results every few months. However, the most recent report I have found covers 1935-40 in Buffalo, New York, and was made by Louis A. Siegel, and published in the New York State Journal. This has been of considerable aid as an outline in preparing some of the tables to be shown later. As brought out in his paper, one of the first investigations to startle the profession was made by the New York Academy of Medicine and reported in 1933. This report was so incriminating, that, threatened with even lay investigation, the profession awoke to do its own house cleaning. This county society is very interested in obstetrics, probably more so than any other one particular branch of medicine, as evidenced by the number that practice this art, by their willingness to attend obstetrical clinics and available post-graduate courses, and by their pro and con discussions of obstetrical happenings, good or bad. It has been my thought, and I believe that of others in the society, that our obstetrical record was a little under par, and this thought primarily initiated the review. As you notice the statistics, which are definitely "undoctored," you will realize that we are doing obstetrics about as well as the rest, much better than many, but there is still room for the continuance of improvement. It is my earnest hope that fulfillment of the recommendations made at the close of this paper will afford the desired improvement and give us an outstanding record, of which

The Author:

Dr. Parker was graduated from Emory University School of Medicine in 1926 and is now practicing in Greenville, limiting his work to obstetrics and gynecology. He was a charter member South Atlantic Association of Obstetricians and Gynecologists.

we all will be justly proud.

TABLE 1.

Total No. Deliveries	6413
Total Death (uncorr.)	53
Uncorrected Mortality	.82%
Less Septic Abortions	.65%

Total number of deliveries is 6,413. Total pregnancy deaths were 53, giving a mortality percentage, uncorrected, of .82, or 8.2 deaths per thousand. The fallacy of including abortion deaths in a maternal mortality study such as this is evident and it has been recommended they be omitted. Deducting the thirteen septic abortion deaths gives us a mortality of .65%. Please keep in mind that this rate is figured on all deliveries and deaths in which pregnancy is present, except abortions, and not figured on deaths occurring in live births only. Our state and national rate is deducted from deaths per thousand live births.

TABLE 2—Causes of Deaths

Accidents and Coincidental	17 or 32%
Toxemias of Pregnancy	13 or 24%
Septic Abortions	13 or 24%
Hemorrhage	6 or 11%
Puerperal Sepsis	4 or 7%

The outstanding cause of death is the group of cases termed accidents during pregnancy, labor, and the puerperium and cases in which pregnancy may be merely coincidental. 17 deaths or 32% of the

total occurred in this group. As shown in Table 3, 12 different diagnoses have been made as the causative factors in this group. Embolic and thrombotic deaths account for seven of the seventeen. The mesenteric thrombosis and two of the pulmonary embolic deaths were confirmed by autopsy. An effort was made to find some cause other than pulmonary embolus in the other three cases, but, from study of the charts and absence of autopsy, the diagnosis must be accepted. Mention should be made of the increased incidence of such deaths following operative deliveries, three of these occurring following section, and also of Steiner and Lushbaugh's proof that pulmonary emboli sometimes are caused by the particulate matter of amniotic fluid and meconium being forced into the blood stream by severe uterine contractions and/or abdominal pressure. These cases too are characterized by shock, pulmonary oedema and death.

The one case of ruptured uterus occurred in a young gravida VI admitted with temperature 101.2, pulse 156, foul vaginal lochia, frank breech and a cervix not fully dilated. No attempt at delivery made, but given fluids and Pantopon. Uterus ruptured in about 10 hours and patient in such profound shock that she died before she could be transfused and operated. Plasma given to no avail. I feel certain the result would have been the same had the patient been transfused and not in such profound shock as to allow operation.

One case paralytic ileus following section, and one case bacillary dysentery that delivered spontaneously in bed and died three days later. Autopsy showed bacillary dysenteric ulcerations of the colon.

TABLE 3.—Accidents and Coincidentals

Pulmonary Embolus	5
Mesenteric Thrombosis	1
Cerebral Thrombosis	1
Ruptured Uterus	1
Paralytic Ileus	1
Bacillary Dysentery	1
Pernicious Anemia Preg.	1
Spirochetal Lung Inf.	1
Lobar Pneumonia	1
Thyroid Crisis	2
Diabetes	1
Essen. Hyper. Rectal Hem.	1

One case of pernicious anemia of pregnancy admitted with RBC 1,120,000 and hemoglobin 50%. She also had a high fever due to a pyelitis, and, despite repeated transfusions, died in two days. Yes! No prenatal care.

The spirochetal lung infection followed a section, and will be discussed under that group. The lobar pneumonia patient was admitted with a severe upper respiratory infection and was delivered by low forceps two days after admitted. She developed bilateral lobar pneumonia and died ten days later. Admitted with RBC 2,510,000.

Note that 7 of these 17 cases died pulmonary

deaths. The great majority of the toxemic deaths are finally pulmonary. Any obstetrical patient near term with a definite respiratory infection, or the development of any chest findings, should be looked upon as a gravely ill patient; and, if she is a toxemic, the prognosis is bad.

The two thyroid cases were 4 and 5 1/2 months pregnant, respectively. Both had hysterotomies under local anesthesia. One had been under medical treatment for six weeks with a BMR of plus 32. In addition, she had a hypertension 170/100, and a glomerular nephritis with albuminuria and hematuria. She died in five days with elevated temperature and pulse, no leucocytosis, negative urine culture, and absence of any other signs of infection. The other case had shown no response to conservative treatment over a period of two months for hyperemesis gravidarum. Temperature and pulse began to rise after operation and she died three days later with temperature 108 degrees and pulse 160. No apparent cause unless thyroid crisis responsible. Unfortunately, no autopsy.

One diabetic admitted near term for induction of labor while the diabetes was apparently under complete control by her internist. Artificial rupture of membranes was followed by labor, but also accompanied by blood pressure 166/90, sugar, acetone, and diacetic all four plus, temperature 103, marked dyspnoea and pulmonary oedema. In an effort to relieve respiratory embarrassment, and with almost complete dilatation of the cervix, one Dührssen incision was made and forcep delivery done without difficulty. Patient was unconscious so no anesthesia necessary. Some immediate improvement, but not sustained and patient died about eight hours later. Despite insulin and glucose this apparently was an uncontrollable diabetic situation. This patient had been advised by her internist not to become pregnant, and, after conception, abortion was advised but not permitted. Authorities agree that diabetes and pregnancy are bad bed fellows.

The last case of this group was admitted on surgical service with rectal hemorrhage, essential hypertension, hemoglobin 45%, pain about umbilicus. Exploratory lap after negative proctoscopic, and nothing abnormal found. The uterus revealed an early pregnancy and it was massaged vigorously with hopes of producing abortion. Tubal ligation. Patient died six days later (aborted day of death). No autopsy and no definite cause of death can be determined from study of chart. Certainly the pregnancy was coincidental in the handling of, and in the death of, this case.

TABLE 4.—Toxemia Mortality

1938	3 deaths.....	70 Tox.....	4.2%
1939	4 deaths.....	45 Tox.....	8.8%
1940	1 death	90 Tox.....	1.1%
1941	5 deaths.....	49 Tox.....	10.0%
1942	0 death	62 Tox.....	0.0%

Toxemias of Pregnancy:

The toxemias of pregnancy accounted for 13 of the 53 deaths or 24%. It is discouraging to recall from Table 1 that septic abortions caused as many deaths as the dreaded toxemias.

TABLE 5.—Yearly Mortality. All Obstetrical Deaths Except Septic Abortions.

1938-----	9 deaths-----	920 Dels.-----	97%
1939-----	8 deaths-----	1075 Dels.-----	74%
1940-----	5 deaths-----	1287 Dels.-----	38%
1941-----	11 deaths-----	1407 Dels.-----	78%
1942-----	7 deaths-----	1724 Dels.-----	40%

Just as a break in case discussions, Table 5 also shows our general mortality by the year. You will note that the increase to 11 deaths in 1941 is due largely to the five toxemia deaths that year, as compared to only one in 1940 and none in 1942.

In 1938 there were three deaths out of 70 toxemics, giving a 4.2% mortality. None of the three had prenatal care, all were severe convulsive types, and two were admitted unconscious. One, age 22, had eclampsia with first pregnancy, and she delivered 5-6 months twins spontaneously, but died eight days later. One, age 19, delivered spontaneously a macerated foetus the day of admission. She was never conscious and died a respiratory type death three days later. Autopsy showed streptococcic pneumonitis, hepatic degeneration, hemorrhagic nephritis, anasarca. The other one in 1938 was a 27 year old primipara with fulminating eclampsia that died undelivered in eight hours after admission. I believe all three of these women could have been saved with adequate prenatal care.

In 1939 there were four deaths out of 45 toxemics, with a mortality of 8.8%. Two of these were colored patients, each para XI, ages 42 and 35. Admitting pressure of one was 250/160, and the other 260/165. Both were of the nephritic type. Easy spontaneous delivery of one, a stillborn. This mother died in two hours of cardiac collapse. The other one died, undelivered, as a result of a cerebral hemorrhage with right hemiplegia. One of the two white deaths occurred in a 40 year old para IX who was admitted with a blood pressure of 235/160, was never conscious, delivered seven months stillborn spontaneously, and died in three days. She was also a nephritic type. The other white patient was a 28 year old primipara with a fulminating eclampsia, and she died three days later, undelivered, with a pulmonary type death. This one of the four had prenatal care. I believe that three of these four patients could have been saved from their cardio-vascular renal deaths by puerperal sterilization, two of them after their tenth pregnancies and one after her eight (if one saw fit to wait that long before the sterilization).

In 1940 there was only one death from 90 toxemics with mortality 1.1%. This 40 year old white woman,

para III, had been under medical care for several years due to chronic hypertensive nephritis. She was admitted at seven months with blood pressure 220/130. Labor began spontaneously, but, due to premature separation of placenta and vaginal bleeding, a Braxton Hicks version was done, converting a transverse position to a breech, and an easy extraction done. Shortly afterwards patient had uremic convulsions and died in a few hours. This patient should have had advantage of proper contraceptive advice, or puerperal sterilization, but, failing in this, she should certainly have been aborted of this pregnancy.

1941 was our bad year with five deaths out of 49 toxemics. Mortality 10%. You may recall that this fact seriously interfered with a beautiful yearly drop in our total mortality. Four of the five were young primipara, 14, 16, 19, and 22 years respectively. Three were admitted with severe, continuous convulsions, marked hypertension and four plus everything. No response to active therapy and three died in 28, 24, and 2 hours respectively after admission. All expired with the pulmonary type death. A section was done on one, purely in the interest of the baby, and no anesthesia was necessary. One was undelivered and the other delivered a stillborn spontaneously. I believe this last one had Steiner's disease. Autopsies on two of these, one showing acute parenchymatous nephritis, and one a glomerular nephritis. Three of the four did not have prenatal care. The other toxemic death in 1941 was a 42 year white gravida III. She had a toxemia of pregnancy two years before and a section was done. This pregnancy was normal until near term, when she developed a mild hypertension, three plus albumin and casts, associated with a twin pregnancy. A low section and tubal ligation was done, after which the patient developed jaundice, clay colored stools, and died in eight days. Autopsy revealed diffuse chronic nephritis, chronic interstitial hepatitis and splenitis. Shouldn't she have had tubal ligation at section two years ago, with toxemia then, and 40 years of age?

TABLE 6.—Methods Del. Toxemics

Spontaneous Delivery -----	7
Version & Ext. -----	1
§Section -----	2
Undelivered -----	3

In 1942 there were 62 toxemias, but no deaths resulted, and for which we should be truly grateful. May this year be as good. Table 6 reveals the methods of delivery of the toxemias, and, considering one of the sections almost as a postmortem type, reveals very conservative handling of the deliveries. All of the treatment of the toxemias has been conservative in type, glucose, magnesium sulphate, transfusions, sedation, and avoidance of any operative or shocking deliveries.

TABLE 7.—Toxemias, Continued

Total Number -----	13
--------------------	----

Primipara	7
Multipara	6
Age: Under 30 years	8
30-40 years	1
Over 40 years	4
Prenatal care	3, questionable fourth.
Puerperal Sterilization previously indicated...	5 (6?)
C. V. R. Disease, irrespective of pregnancy	4

In summarizing this entire group, Table 7 is of interest particularly in respect to the following deductions:

(a) Only three, with a questionable fourth, of the 13 cases received prenatal care. It is believed that possibly 10 of the 13 might have been saved with adequate care prior to and during pregnancy.

(b) Four were over 40 years of age and three of these had definite cardio-vascular-renal disease, irrespective of pregnancy, and the fourth died a toxemic death following section.

(c) So much has been attributed to the colored mortality in the south, it might be well to mention that there were seven whites and six colored.

(d) Puerperal sterilization was previously indicated in five and probably six of these cases.

Septic Abortions:

For the sake of brevity the thirteen abortion deaths will be briefly summarized.

Eleven of the thirteen abortion deaths were admitted with fever and/or shock. Two of the thirteen were admitted criminal abortions, one dying of a hemolytic streptococcal septicemia as a result of a perforation of the lower uterine segment, and the other as a result of a septic bronchopneumonia. With the exception of three cases, all died in an average time of 3 1/2 days. This is indicative of the marked virulence of the infection in these cases, and the extreme illness present before being hospitalized. In the future it will be well to remember that this group comprises 24% of our maternal mortality, and, if we have an opportunity, to admit these cases before they start the febrile course.

Therapy has consisted in the use of transfusions, sulfonamides, and a non-intervention policy so far as possible. Only two D & C's were done in this group, and one of these was accounted for by continued uterine bleeding in a severely anemic case, and was done under local anesthesia.

Hemorrhage:

Hemorrhage was responsible for six deaths or 11%. Siegel's Buffalo study showed twice this percentage.

Three of the six cases followed Cesareans and will be discussed under that heading.

Two were due to premature separation of placenta, and both cases had associated a severe toxemia. One delivered spontaneously after artificial rupture of the membranes, but died the same day as a result

of pre and postpartum hemorrhage and toxemia. This case had a supernumerary placenta. The other premature separation was admitted in shock, and, although she had two transfusions, died undelivered in less than twelve hours.

The other hemorrhage death, probably placenta previa, died within one hour after admission. She was in shock upon admission, and there was a history of vaginal bleeding the night before. She was about seven months pregnant. Plasma started but to no avail.

Sepsis:

The so-called "captain of death" in obstetrics, puerperal sepsis, has been demoted to a corporal in this group of cases. There were only four deaths, or 7%, due to sepsis.

Three of the four might be classed as "damned if you do and damned if you don't." A 42 year old colored para XI with blood pressure 182/120, hemoglobin 51%, admitted at term with shoulder presenting. Temperature 102 at time of version. Continued febrile course, developed cough with blood tinged sputum and died in four weeks. Autopsy report of not much value, but evidently sustains clinical diagnosis of hemolytic infection, present upon admission and in puerperium.

One case followed section and will be discussed there.

Third case delivered at home two weeks before admission. Brought into hospital with temperature 102, abdominal distention, foul lochia, hemoglobin 58%, and bronchopneumonia. Died day after admission.

The fourth case was a 39 year old primipara with a spontaneous delivery. Temperature 99 at time of delivery and 102 degrees in 24 hours. Septic course for ten days before death. Autopsy revealed septicemia arising from pelvic peritonitis and abscess in cul-de-sac. This case really runs true to form of the "childbed fever" type.

Cesarean Sections:

Deaths that have occurred following section number 10. These cases have been abstracted in order to give you the age, parity, type section, indications for the operation, length of time lived after operation, and the cause of death.

Commenting briefly on these section deaths, it seems that a Latzko extra-peritoneal section or a Porro was indicated in the last two cases. It will be noted from the table that the last case was admitted with a temperature of 102, and, in addition to this, the chart note mentioned repeated vaginal examinations before admission, with rupture of membranes and labor of 72 hours. In the case next to the last one, it will be noted that this patient had a spontaneous rupture of the membranes 20 hours before the operation.

Insofar as the indications for section are concerned, it was difficult to evaluate some of these due to lack of information on the charts. For ex-

TABLE 8

Age	Parity	Type	Indication	Death Occurred	Cause
31	Primipara	Classical	Fibroids	7th day	Paralytic Ileus
35	Primipara	Classical	Pulmonary regurgitation	5 hours	Uterine Hemorrhage
34	Grav. VI	Low	Placenta previa & 2 previous sections	4 hours	Hemorrhage & Shock
25	Primipara	Classical	"Large Stillborn"	28 days	Spirochetal lung infection
27	Grav. V	Classical	Premature Sep. Placenta	5 hours	Admitted in shock and died of this and hemorrhage
36	Primipara	Low	Contracted pelvis. 5 hr. trial labor	2 days	Pulmonary Embolus
42	Grav. III	Low	Nephritic toxemia. Previous section. Twin pregnancy	8 days	Autopsy: Diffuse chronic nephritis, hepatitis, splenitis.
30	Grav. III	Low	Placenta previa. Transverse position. Previous section	4 days	Autopsy: Multiple pulmonary emboli.
17	Primipara	Low	Contracted pelvis, unengaged post. Trial labor	6 days	Autopsy: Mesenteric thrombosis. Membs. rupt. 20 hrs.
17	Primipara	Low	Cephalo-pelvic disproportion. Brow presentation. Labor 72 hrs. Live baby	3 days	Sepsis. Admitted with temperature 102.

ample, the chart of the patient with the fibroid tumor fails to mention the size, location, etc., of the fibroid. Another such instance was one chart which gave a diagnosis of a "Large Stillborn." In review of the chart of the patient with a pulmonary regurgitation no note was made as to any dyspnoea or hypertrophy or other evidence of decompensation, and certainly in the absence of any of these there was no indication for section.

Attention should be called to the fact that three of these ten women had had previous sections.

TABLE 9

Year	Deaths	Total Sections	Mort.	Del.	Incid.
38	3	77	3:6	920	1:12
39	2	68	2:9	1075	1:15
40	0	61	0:0	1287	1:21
41	2	57	3:5	1407	1:24
42	3	58	5:1	1724	1:29

Table 9 reveals that there was a total of 10 deaths in 321 sections with an average mortality of 3.1. This compares most favorably with the Buffalo average of 5.1. There has been a very marked and steady decrease in the incidence. The ratio in 1938 of 1 to 12 has decreased to a ratio of 1 to 29 in 1942—in other words, we did 2 1/2 times more sections on the same relative number of cases in 1938 than in 1942. This improvement is noteworthy and commendable, but it is felt that further decrease in the number of sections can be expected. It is also believed that the low flap type sections offer better opportunity to lower section puerperal morbidity and mortality, and that the Porro or Latzko sec-

tions are definitely indicated in infected or strongly potentially infected cases.

Summary and Conclusions:

First: Of 6,413 obstetrical cases there were 53 deaths from all causes, giving an uncorrected mortality rate of .82%. Deducting abortions gives a rate of .65%. Per thousand live births, a rate of 2.4.

Second: Other than a miscellaneous group, the toxemias accounted for the largest number of deaths, 13 or 24%. The same number of deaths resulted from septic abortions.

Third: Prenatal care, despite educational programs, is not being sought for and taken advantage of by the laity, particularly country residents and low income groups. A very large percentage of toxemia deaths could have been prevented.

Fourth: Puerperal sterilization or adequate birth control offers one of the most important means of reducing maternal mortality, particularly in the older and higher parity cases. A large percentage of these die due to cardio-vascular-renal disease aggravated by pregnancy.

Fifth: The decreasing incidence, the indications, and the general handling of cesareans has reached a reasonably favorable level.

Sixth: Conservative type therapeutics by all attending physicians, particularly in the toxemias, has been almost universally followed and is to be commended.

Seventh: More notes on the charts by the attending and intern staffs, especially in gravely ill patients, than found in many of these death cases, is to be greatly desired.

Eighth: The adoption of a birth certificate giving

pertinent information, on the reverse side, covering any complications or operative procedures, and their indications, such as is now used in some states, would be of great statistical value. This would be of confidential nature and not copied in certifications or transcripts.

Ninth: Mention has been made of some red blood cell counts and hemoglobin determinations, and it is apparent that anemia is much more frequent than expected—in fact, to the extent that routine therapy in this respect, during pregnancy, would not be amiss.

Tenth: 12 autopsies were performed in 53 deaths or 22%. The council on hospitals has ruled that,

in order for a hospital to be approved for intern training, 15% of autopsies must be obtained and that at least 36 in number annually will be required, not including those on stillbirths. The importance of autopsy findings does not need comment.

I take this opportunity to thank Dr. O. M. Hooker, Resident at General Hospital, Miss Pickett and Miss Grobusky, record clerks at the two hospitals, for their aid in preparing this report.

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THE FOUR HORSEMEN

"Ignorance, poverty, disease, and indifference are the Four Horsemen that sweep across this state and spread desolation, destruction, and death," was the statement made by Mr. A. L. M. Wiggins of Harts-ville, in a recent address.

With this thought we are in entire agreement and have so stated upon numerous occasions. We have also said that any program aimed toward the eradication of desolation, destruction, and death must be centered not upon just one but upon all four of these Horsemen.

Perhaps a simple story—and it is a true one—will illustrate our point.

Little Johnny — whose father was a tenant farmer — developed croup. When the usual family remedies failed, Aunt Sallie — the general adviser of the neighborhood — was called. Aunt Sallie made no charges for her ministrations and was always glad to demonstrate her abilities. Preparing one of her special poultices, Aunt Sallie applied it to Johnny's chest. The hours wore on and the little boy — in spite of the poultice—grew worse.

In final desperation, the family physician was summoned. A single glance at the little patient was all that he needed. Putting the boy into his car he rushed him to the hospital. But it was too late—the boy died as a tracheotomy was being performed.

What killed this boy? The death certificate read "Laryngeal diphtheria," but it could have also read "ignorance, poverty, and indifference." Ignorance was there in full force — ignorance on the part of the family in relying upon the ministrations of a well meaning but ignorant woman to care for a sick child. Poverty lurked in the background, causing the family to choose—and how fatal was the choice—the free attentions of untrained Aunt Sallie in preference to the scientific care of a physician. Back of them all stood indifference—for several months before Johnny's death, a monthly clinic had been held within a mile of Johnny's home where diphtheria toxoid was administered free. But Johnny had never been to the clinic.

Johnny should be alive today — but he is dead. What else could be expected when all Four Horse-

men fought in unison against one little boy.

H. R. 395

On January 3, 1945, Mr. Dingell introduced a bill in the U. S. House of Representatives, registered as H. R. 395. It is the same bill which, known in 1944 as the Wagner Murray-Dingell Bill, was so widely discussed by physicians and others last year. How much we will hear of this particular bill this year remains to be seen.

Whoever wrote the preamble is a master of the terse and Utopian statement, and we publish it for the benefit of those who have not had the opportunity to read this portion of the bill, calling particular attention to the phrase which we have printed in black face type.

"A Bill to provide for the general welfare; to alleviate the economic hazards of old age, premature death, disability, sickness, unemployment, and dependency; to amend and extend the provisions of the Social Security Act; to establish a Unified National Social Insurance System; to extend the coverage, and to protect and extend the social-security rights of individuals in the military service; to provide insurance benefits for workers permanently disabled; to establish a Federal system of unemployment compensation, temporary disability, and maternity benefits; to establish a national system of public employment offices; **to establish a Federal system of medical and hospitalization benefits;** to encourage and aid the advancement of knowledge and skill in the provision of health services and in the prevention of sickness, disability, and premature death; to enable the several States to make more adequate provision for the needy aged, the blind, dependent children, and other needy persons; to enable the States to establish and maintain a comprehensive public assistance program; and to amend the Internal Revenue Code."

S. 191

Senator Hill introduced a bill in the U. S. Senate recently which, if enacted into law, will have far reaching consequences in South Carolina. The Bill provides for "grants to the states for surveying their hospital and public health centers and for planning construction of additional facilities, and to

authorize grants to assist in such construction."

According to the provisions of the Bill, a sum of five million dollars would be available to the states for making comprehensive surveys of hospitals and public health centers and one hundred million dollars would be available annually for the construction of public and non-profit hospitals. The monies would be administered under the supervision of and with the approval of the Surgeon General of the U. S. Public Health Service.

OUT IN CALIFORNIA

Dr. George H. Kress, Secretary of the California Medical Association was kind enough to send us a copy of the San Francisco Examiner of Jan. 25, which carried a story that is of interest to every physician. Since what is happening in California may be happening in other states, we will watch with interest what takes place in that great state during the next few weeks and months.

The story is headed, HEALTH SERVICE BILL GIVEN TO LEGISLATURE, and the opening paragraph reads, "Under the joint sponsorship of a group of both Republicans and Democrats, Governor Earl Warren's 'Prepaid Health Service' bill, setting up a system of compulsory health insurance in California, reached the State legislature today."

The basic medical services provided under the prepaid medical care program, are described as follows,

Individuals under the proposed State system, the bill asserts, are entitled to "general practitioner services rendered by a physician or surgeon licensed in California, whenever such services are required by the standards of good medical practice for preventive, diagnostic, therapeutic or other medical treatment or care."

"These general services may be performed at the physician's office, or in a hospital or clinic," or anywhere else in California "in accordance with the standard of medical practice in the community in which the service is rendered."

In addition, the bill provides the following "basic services" —

Consultation and specialist services in addition to those of the general practitioner.

Laboratory and X-ray services.

Necessary hospitalization, excluding ambulance service, for not more than twenty-one days a year for each separate and distinct illness or injury.

Drugs, medicines and biologics, bandages, splints, and other supplies prescribed by the attending physician and surgeon. Drugs other than preventive biologics are not included except when used in course of treatment in a hospital.

Such general nursing service as is afforded by the hospital in which treatment is given, but not private or special nursing service.

Dental services "for the extraction of teeth, and for treatment of acute infections of the teeth, gums, alveolar processes and the bone adjacent thereto, or fractures of the jaw."

With the exception of these dental services and the "general practitioner" services first mentioned, all the other services "shall be furnished only upon the certificate of the general practitioner or specialist to whom the patient is referred." Presumably, dental fillings and bridges would not be included.

Basic services are to be furnished for not more than one year for any one illness or injury, and will be provided for "tuberculosis and mental infirmities or disorders" only up to the time of diagnosis of such conditions.

Provision is made for amendment of these basic service provisions by a two thirds vote of the eleven man authority which will administer the prepaid medical service system. The Governor may suspend the operation of any such rule or regulation in his own discretion. Except for modification of the basic services enumerated in the bill, the authority may adopt rules and regulations by mere majority vote of its members.

Increased Service

When the financial condition of the Health Service Fund warrants, the bill sanctions extension of service to provide one or more of the following: Increase of hospitalization period, additional drugs, additional medical or dental services, optometrical services.

Administration of the system will be in the hands of the California Health Service Authority, which will function with the Department of Public Health. One of the eleven members of the authority will be the State director of public health, and the Governor will appoint the other ten for four year terms. Salaries of the members will be \$25 a day while attending meetings, plus their actual expenses. The Governor will designate the chairman.

The authority is to consist of three representatives of employers, including one employer of agricultural labor; three employee representatives, two from organized labor and one public employee; three licensed physicians, one of whom is experienced in hospital management, and one dentist.

Except for the collection of contributions from employers and employees, on the basis of 1½ per cent from each on salaries up to \$4,000, all details will be administered by the authority. Collections will be handled by the Employment Stabilization Commission, which already collect unemployment insurance funds in California.

The authority's first duty will be to set up rules and regulations and fix fees to be paid for all health services furnished under the act. The authority need not make these charges uniform throughout the State.

Broad powers are given the authority in fields allied to health service. It may investigate hospitals, groups of registrants (banded together in various health services) employers and fraternal or charitable or other nonprofit health service organizations which may enter contractual relations with the State service.

The State treasury is pledged to assure the operation of the health service system until June, 1949. In a final section, the bill pledges the "faith and credit of the State," and adds:

"It is the intention and purpose of the legislature and Governor of this State that, in the event the funds herein provided are insufficient to accomplish this operation, such additional funds shall be provided as may be necessary, to the end that the health and safety of the people of the State be properly and adequately safeguarded."

The Ten Point Program

M. L. MEADORS, EXECUTIVE DIRECTOR AND COUNSEL

"BLUE CROSS" BILL MEETS OPPOSITION

The proposed enabling act which would permit the organization in South Carolina of a Hospital Service Corporation which might qualify according to "Blue Cross" standards was introduced in the Senate in accordance with the plan referred to on this page last month.

Following appearance by the members of the group actively interested in the Bill, before the Senate Committee on Medical Affairs, at which time the Bill was presented and fully explained, it was introduced in the Senate by that Committee on January 23. Although introduced as a Bill of the Committee on Medical Affairs, it was immediately referred to the Committee on Banking and Insurance and, at the request of certain opponents of the Bill, a public hearing before the latter Committee was set for Wednesday afternoon, January 31.

All of those interested in the matter were promptly notified and arrangements were made which resulted in a substantial representation at the hearing of the proponents of the Bill. Among those present were Dr. W. R. Wallace and Dr. V. P. Patterson of Chester, Presidents respectively of the South Carolina Medical Association and of the State Hospital Association, Mr. A. B. Taylor of Spartanburg, Mr. Roger S. Huntington of Greenville, Dr. Julian P. Price of Florence, Mr. F. O. Bates, Superintendent of Roper Hospital and Mr. J. B. Norman, Superintendent of Greenville General Hospital. Also the following other hospital Superintendents: Rev. W. M. Whiteside, Baptist Hospital, Mr. J. B. K. DeLoach, Columbia Hospital, Mr. George W. Holman, York County Hospital; and Mr. T. C. Callison, Assistant Attorney General and a trustee of the Baptist Hospital in Columbia. There were also others but these, together with your Director, took the most active part in the discussion which ensued.

The meeting was presided over by Senator J. M. Lyles of Fairfield, Chairman of the Committee, and the proponents of the Bill were asked to present it and explain its principal purposes and provisions. This was done by Mr. Norman, Dr. Price and Mr. Huntington, representing respectively the three

groups vitally and actively interested in the legislation—the hospitals, medical profession and business and industry. The remarks of each of these gentlemen were developed fully through questions put by several of the Senators on the Committee and, at their conclusion, the Bill had been rather fully explained.

The opposition was then heard from and was led by Mr. Heyward of Columbia, a prominent insurance man who apparently acted as spokesman for those who are openly opposed to the Bill. (Mr. Heyward, incidentally, is one of those who participated on the Open Forum discussion of the Ten Point Program over Radio Station WIS a week following the broadcast of an explanation of the Program by Drs. Julian Price, Hugh Wyman and Gordon Spivey and your Director, shortly after the Program was instituted in September.) The principal objections voiced by Mr. Heyward and one or two others who joined him in criticism of the Bill were that it did not sufficiently set out in detail the services to be guaranteed and the rates to be charged; that it is referred to as a benevolent and charitable organization whereas the subscribers would be required to pay for the services and would not receive them gratis and that the proposed corporation should be fully under the control of the State Insurance Department.

In reply we were able to point out the fact that no legislative acts authorizing the organization of insurance companies, mutual, stock or otherwise, and no statutes which permit such corporations organized in other states to engage in business in South Carolina attempt to set forth in detail the itemized risks to be insured against or the premiums to be charged and that all of these things clearly are matters of contract. We were able to go further and show that under the proposed Bill exactly this is required in so many words to be set forth in the contracts to be entered into by the corporation with its subscribers and that these contracts must be submitted to the Insurance Commissioner along with other documents, and a certificate obtained from him and filed with the Secretary of State showing compliance with the law before the corporation would be permitted to operate. The Bill provides also, as we pointed out, that the corporation shall file annually with the State Insurance Commissioner a statement verified by two of its principal officers showing its condition, including salaries paid, business in force and working capital, this statement to be in such form and to contain "such other matters as the Insurance Commissioner shall prescribe."

Among other things which the Bill requires to be filed with the Insurance Commissioner along with the proposed contracts and before it can begin to operate, are copies of its by-laws, contracts between the corporation and the participating hospital and a financial statement showing the amounts of contribution paid or to be paid and the name of each contributor and the terms of the contribution. In short, it seems that the Bill in its present form includes every reasonable requirement to insure adequate supervision by the Insurance Department.

Expressions in the Bill referring to the corporation as a benevolent and charitable organization are used in connection with the provision that it shall be exempt from taxation and their use would hardly seem to provide the opportunity for unfair competition with the commercial insurance companies, as their representatives seem to fear.

Present at the hearing also was Mr. Haskins E. Coleman, Executive Director of the "Blue Cross" organization in Richmond, Virginia. With his store of knowledge of the general structure and technical features of the plan, he was able to supply much information of value in response to some of the inquiries. The hearing lasted for approximately two hours and no action was taken on the Bill immediately.

On Wednesday of the following week, February 7, however, after a brief further discussion of the Bill before the Committee, at which time we were again present, the Bill was reported favorably by the Banking and Insurance Committee and printed copies containing the favorable report were on the desks of the Senators on Tuesday, February 13. On the same or the following day, however, the Bill was recommitted and, as this is written, it is still before the Banking and Insurance Committee and another public hearing is set for Wednesday afternoon, February 21.

In the meantime, although not as early as had been desired, due to conflicting business of the Committee or engagements of the members, the Bill was presented to the Medical Affairs Committee of the House of Representatives and was unanimously approved for introduction in the House as a Committee Bill.

While we did not expect an easy passage of the Bill, the opposition has been somewhat more vigorous and determined than had been anticipated. We cannot help wondering whether the same sort of difficulties were experienced in all of the forty-two states where "Blue Cross" plans are now operating. In some of these, however, it should be noted, it was not necessary to pass special enabling legislation but the companies were organized under existing statutes.

We would not presume to criticize the motives or methods of those who are opposed to the Bill nor would we advocate for a moment any procedure but that which permits free opposition on the part of any individual or group which feels that its in-

terests are threatened by proposed legislation. However, we are more than ever convinced that this contest demonstrates once again that the real danger to American institutions lies in the failure of groups and individuals to cooperate in efforts to work out voluntary methods by which people may provide themselves with adequate security, for thereby they hasten the day when such voluntary efforts may be thrown into the discard and rendered completely unnecessary and out of order, through some federal statute for compulsory prepayment for everything, under a comprehensive and all-embracing program of Government controlled social security.

Despite this, we are optimistic about the ultimate passage of the "Blue Cross" Bill and it is hoped that by next month's issue, we can report more favorable news regarding it.

HOSPITAL SURVEY PROPOSED

A Bill which, if enacted into law, will provide for the making of surveys of hospitals, health centers and related facilities in the state was introduced in the Senate on February 6 by the Medical Affairs Committee of that body. It was read the second time but then was held up temporarily and at the last report was still in the Senate for further consideration.

The proposed survey is in line with the national project promoted by the Commission on Hospital Care, referred to in this column a few months ago. Under the terms of the Bill now in the State Legislature, the survey would be made by the State Board of Health, through its duly authorized representatives, who would be directed to "make surveys of the location, size and character of all existing public and private (proprietary as well as non-profit) hospitals, health centers, and other related facilities in the State, evaluate the sufficiency of such hospitals, health centers, and related facilities for furnishing adequate hospital, clinic, and related services to all the people of the State and compile such data and conclusions, together with a statement of new or expanded facilities necessary, in conjunction with existing structures, to supply such services."

The Bill provides also for the appointment by the State Board of Health of a State Advisory Council consisting of representatives of various interested groups in the State, both non-government and government agencies, which would be directed to consult with the Board in carrying out the purposes of the act.

The Bill is directly in line with and designed to implement the Bill now before Congress (S 191), sometimes referred to as the Burton-Hill Bill, providing for an appropriation of \$5,000,000 for the making of such surveys and plans throughout the nation. A second part of the same Bill before Congress would provide also for Federal assistance in a very substantial way toward the construction and administration of hospitals found by the survey to be necessary or desirable. The Bill before the State

Legislature, therefore, would authorize the State Board of Health to apply to the Federal Government for financial or other aid and to accept and receive Federal funds or advances and to accept provisions of the acts of Congress along the lines referred to.

Some suggestion has been made that the Advisory Council, provided for in the Bill, be appointed by the Governor, with specified numbers of representatives of the medical profession, the Hospital Association, the State Board of Health, the nursing and dentistry professions and others. Such an amendment may be proposed before the Bill is finally adopted but no material change in its substantial structure is probable.

All of this proposed legislation fits in with and no doubt originated from the plan suggested by Dr. Thomas Parran, Surgeon General of Public Health Service, for a nation-wide coordinated system of hospitals and health centers. The plan was referred to in this column last month and the proposed survey, to be followed by a huge construction program, is further indication of the current trend in legislation to provide medical and hospital care.

MEETING OF THE COLUMBIA MEDICAL SOCIETY

The Program Director was invited to speak to the Columbia Medical Society at its business meeting on the evening of Monday, January 22. The meeting, held at the Columbia Hotel, was well attended and considerable interest in the Ten Point Program and the proposed "Blue Cross" Plan was manifest.

Our time was about equally divided between discussion of the Program generally and of the efforts under way to secure adoption of the "Blue Cross" bill. At the conclusion of our remarks, at least one of the members of the Society expressed to the meeting his very favorable reaction to the Plan as a whole, stating that, in his opinion, if some such plan for prepayment of hospital care could have been promoted and developed many years ago, the profession generally would now be in a much more favorable position.

The Society's courtesy in expressing formally, on motion, its thanks for our efforts in discussing the Program and Plan, was sincerely appreciated.

CONWAY LIONS CLUB INDORSES "BLUE CROSS" PLAN

On Friday, February 9, we were invited to speak to the Lions Club in Conway on the Ten Point Program and the proposed "Blue Cross" Plan. An unusually delightful meeting was enjoyed at which the members of the profession in Conway were especially well represented.

The remarks on the Program were general and most of the time was devoted to discussion of the "Blue Cross" Plan and the organization which would be possible under the enabling act now before the

Legislature.

The audience was very attentive and indicated genuine interest in the subject. Several questions were asked at the conclusion indicating serious thought on the matter. Following this, Mr. Ervin Dargan of Ingram-Dargan Lumber Company pointed out the similarity between the "Blue Cross" idea and the plan now in operation by his company through which the employees are able to make prepayment for hospital and medical care.

On motion of Mr. Dargan, which was readily seconded and passed, apparently unanimously, the efforts to secure the passage of the Bill were indorsed and the Club went on record as favoring its adoption and the organization of a "Blue Cross" Plan in South Carolina.

THE ENGLISH PANEL SYSTEM

Following the meeting with the Conway Lions Club, we had the pleasure of talking with one of the members, a former resident of England, about the operation of the state controlled system of medical practice in that country. This gentleman has had opportunity to observe directly and has personally experienced the effects of medical practice under the Panel System.

According to him, the plan is far from satisfactory. Many of the more skillful members of the profession, whose practice and income are established, do not affiliate with the Government system but devote their entire time to their private practices. On the other hand, those doctors who from a standpoint of experience, lack of ability or other cause do not occupy places near the top of the profession, make up a large part of the rolls of the panel doctors. Naturally, there is a strong tendency among these to become true Government employees and to lose their professional outlook. The better doctors on the panels have more patients than they can take care of and, naturally, the patients do not receive the same care and professional interest they would receive under a system of private practice. The incentive which prompts the doctor in private practice to work long hours and constantly to strive to perfect his skill is, in many instances under the Panel System, noticeably lacking. The feeling of responsibility to and interest in the patient, on the part of the physician, is not the same, apparently, where the Government pays the bill.

FLORENCE CLUB MEMBERS HEAR OF PROGRAM

Two of the service clubs of Florence were the recipients of information regarding the Ten Point Program and the "Blue Cross" Plan late in January. On the 26th, Dr. Julian Price spoke to the Lions Club and on Thursday of the following week, the 29th, we undertook to do likewise by the Kiwanians. Both organizations indicated their interest.

PUBLIC HEALTH NEWS

FIGURES TELL THE STORY OF PUBLIC HEALTH'S PROGRESS IN SOUTH CAROLINA

A comparison of figures in the annual reports of the State Board of Health for the fiscal years 1937 and 1944 shows encouraging progress in public health in South Carolina during the last seven years.

Of special significance is the fact that the number of babies born in 1944 increased more than 11,000 over those born in 1937, while deaths from all causes decreased more than 2,000.

Marked decreases in deaths from tuberculosis, malaria, diphtheria, typhoid fever and pellagra were made. Many other diseases, including syphilis, also show a decline as causes of death.

Infant and maternal deaths, two of the State's major health problems, have been steadily lowered in number and rate since 1937, and will probably continue their downward trend as a result of strong emphasis being placed on them through the Emergency Maternal and Infant Care program.

The greatest reduction in deaths from any one disease occurred with malaria, which showed a drop from 450 in 1937 to 68 in 1944. Other reductions during the 7-year period include pellagra from 197 to 31; tuberculosis from 950 to 630; diphtheria from 77 to 44; maternal deaths from 295 to 201; infant deaths from 3,133 to 2,898; and stillbirths from 2,246 to 1,797.

Particularly interesting is the fact that South Carolina is the only State in the United States that showed a decrease in typhus fever cases during 1944. Every other State reporting the disease showed an increase.

The total number of births and the total number of deaths from causes shown above, together with the rates, for 1937 and 1944 are listed below.

	Number		Rate	
	1944	1937	1944	1937
Live Births ¹	49,366	38,282	25.1	21.9
Total Deaths ¹	18,377	20,771	9.3	11.9
Infant Deaths ²	2,898	3,133	58.7	81.8
Stillbirths ²	1,797	2,246	36.4	58.7
Maternal Deaths ²	201	295	7.7	4.1
Tuberculosis	630	950	32.0	54.3
Diphtheria	44	77	2.2	4.4
Typhoid Fever	31	197	1.6	11.3
Pellagra	71	225	3.6	12.9
Malaria	68	450	3.5	25.7
Syphilis	280	320	14.2	18.3

¹Rate per 1,000 population

²Rate per 1,000 live births

All other rates per 100,000 population

WHAT TO DO IF BITTEN BY A SUSPECTED RABID ANIMAL

By H. M. Smith, M.D., Director Hygienic Laboratory

(This article was prepared for the laity, but it answers so many questions which every doctor is asked to answer that we present it in full.—Editor.)

1. In all cases of animal bite, wash the wound immediately with soap and water. *Consult a doctor or report to the health department* for advice as to whether further local treatment is needed and whether anti-rabic treatment should be given.

2. *Do not kill the animal unless absolutely necessary.* If an animal is killed in the early stages of rabies, the brain examination may show no evidence of the disease. There is usually a better chance of proving the animal rabid if it dies from the disease. However, if it is necessary to kill the animal, care should be taken not to damage the head.

3. *Capture the animal*, if possible, and keep it penned up for ten days. If it remains well and alive during this time, this proves it was not rabid at the time of biting. If it was in the early stages of rabies at the time of biting, it will rapidly grow worse and die or be in a dying condition within one week. The biting animal should be penned up in such a manner that it cannot escape.

4. If the biting animal disappears and cannot be captured within 24 to 48 hours, the person bitten should seek the advice of a physician, local health officer, or the State Board of Health. It is highly important that every person bitten on the face or severely bitten elsewhere should consult a physician or health authority at once.

5. If one of a group of dogs bites, and there is a question as to which dog did the biting, the entire group should be confined and kept under observation for the 10-day period. If all the dogs in the group remain well and normal, there is no danger of rabies developing from the bite. If any one of the dogs in the group does go mad, anti-rabic treatment should be taken by all persons bitten.

6. *Laboratory Examination* — If for any reason the dog is killed or dies within one week after biting, its head should be removed close to the shoulders and placed in an ice-packed container which will not permit the leakage of fluids and expressed prepaid or brought to the laboratory for examination. It is against the postal laws to mail animal heads. The Railway Express Company will accept animals' heads for shipment under the following conditions: "The head of the dog or other animal . . . must be placed in a tin or metal container, which will not permit the leakage of fluids; such container shall then be placed in a second wood or metal container

with ice packed around it; such outside container must be so constructed that it will not permit the leakage of the ice water." Animal heads may be sent or taken to the Hygienic Laboratory, S. C. State Board of Health, Wade Hampton State Office Building, Columbia, S. C. In case the Wade Hampton State Office Building is closed when heads are brought, contact the Highway Patrol Office in the basement of the adjacent Calhoun State Office Building, which office is always open and will get in touch with the proper persons at once. *Do not bring live animals to the laboratory.*

7. Even though the biting dog has previously been inoculated against rabies, it should be confined. While a dog that has been given rabies vaccine stands less chance of developing rabies than does the dog that has not received the vaccine, it is quite possible for a vaccinated dog to go mad.

8. All dogs and cats bitten or suspected of having been bitten by a rabid animal should be killed at once or quarantined for at least 3 months. There is

a strong possibility that every animal bitten by a rabid animal will go mad. It will develop the disease usually within 3 or 4 weeks, but may develop it any time within 3 months from the date it was bitten. The owner who knows or suspects that his dog or cat has been bitten by a rabid animal and who fails to kill it or keep it securely chained or penned up day and night for not less than 3 months, is subjecting his own family and his neighbors to a serious danger. Valuable animals may be given anti-rabic treatment by a veterinarian, but since the treatment does not always protect, they should also be kept confined and under observation for not less than 3 months. The meat of cattle and hogs bitten by rabid animals is quite safe for human use, provided the animals are slaughtered within a period of 7 to 10 days from the date they were bitten. The milk of cows can be used with safety during the period of observation, but should the animal become sick, either from rabies or any other cause, the use of the milk should be discontinued since it may not be wholesome.

CORRESPONDENCE

In France
4 Jan., 1945

Dear Dr. Price,

It has been some time since I received your cleverly conceived and well written letter. The delay in replying is the time worn excuse, lack of time, and partly due to the fact that I really needed some time before trying to give an honest answer to your questions.

First of all, I must tell you about my work. I'm sure this will in part influence my answers. I'm in a combat unit and perpetually at or near the front. Our job, to conserve the fighting strength, is a tough one. The battle casualties, that constitute every variety of trauma known to man, are handled in a routine manner. The means to care for them is adequate and only minor changes could be recommended. The non-battle variety, exhaustion, N. P.'s, and those who just don't want to, or will not, fight, comprise our greatest headache. The work done by our psychiatrist is notable. Some of his results are amazing. No doubt the war is creating a future for this branch of medicine. In short, we are always busy, working 90% of the time under the gun.

America means more to me now that I know how the other half lives. America is the greatest of all nations, and will continue to grow under the proper leadership and guidance.

South Carolina is a potentially great state. Naturally I feel close to her and wish to return to try to make it a better place to live, and I hope to make a greater contribution than I did before the war.

No one here feels that the civilians are doing their best. The reason for this is the comparison between the English, and German civilians. Another reason is that we see the horrors of war at first sight, and the price our men are paying. We know of the various shortages in such vital things as artillery shells and tires. We think the people at home just don't understand. If they did, there would be no strikes, or absenteeism or change of jobs, or

loafers, and they would work 18 hours if necessary at straight pay.

I refuse to answer the one about the political campaign. I can't be quoted on that question.

Ah! The Race Question — and South Carolina is a big offender. Every soldier in this Theater of War was insulted at recent remarks directed at the Nisei. One battalion of American-born Japs have saved the lives of countless other Americans. They are the acme of fighting perfection. We admire and appreciate them. The colored soldier is no different. He must be given every privilege of the white man. He should be given equal education, jobs, wages, and the right to vote as he pleases. Why not?

Labor must be allowed to organize but it should not have the power of the closed shop. Closed shop destroys the very principle for which we are fighting.

The soldier's return should cause more interest in education, particularly, vocational education. The Army has made a great effort to develop specialists, and I believe this will cause many of them to seek more training in every imaginable field. The soldiers think they will organize and run things. I can not believe this, for I think returning soldiers will not act very differently from those who returned after the last war.

Seeing the system that was set up by the Germans in Alsace Lorraine for medical care has divorced me from any thought of wholesale socialization of medicine. I had the opportunity of talking to a very intelligent woman doctor in La Petite Pierre, who convinced me that State Medicine is an unnecessary evil. It is perfectly true that the fortunate must provide for those who have not the means to provide themselves adequate medical care. That is as far as I believe socialized medicine should ever be carried. I believe the various schemes of insurance and health benefit associations should be controlled by the doctors. The trial and error method will eliminate undesirable systems of insurance medicine.

As far as the A. M. A., I don't believe I have

talked to a doctor in a long time who believed that the A. M. A. was doing a job for the doctors commensurate with its capabilities. The reasons for distrust, etc., were often vague and nebulous, and, no doubt, many were without reason. I can only say that a lot of doctors are suspicious of the A. M. A.

Medical politics, a paragraph in the November issue of the Greenville County Society Bulletin, touches one thing wrong with the State Association. The ten point program is an evolutionary step, and I believe, in the right direction. Having a lawyer for Counsel is an excellent idea and should add greatly to the progress of medicine in S. C.

After the war, I hope to spend enough time in a residency or post graduate school to be able to restrict my practice. Doing this, I probably will move to a larger town to practice. That is all I want. If the association can assist me in attaining this goal, it will be greatly appreciated.

It is gratifying that the State Association seems to realize the many problems of the future and is actively doing something to solve them, and I'm sure the Secretary deserves much credit for this.

To again receive the Journal would be a pleasure. Reading material here is very scarce. I do receive the A. M. A. Journal and the Greenville Medical Bulletin and they are read by all the other officers after I finish them.

No doubt this letter leaves much to be desired. As I wrote this tonight, the noise was incessant but fortunately all was outgoing. Even so, we all jump with each report. I promise to try again and will do better in my next attempt.

I'm sure that my appreciation of your letter is shared by all those who received it. It certainly makes us feel that we are remembered.

Thank you very much, and I join you and millions in the wish that we will be home again, and the sooner the better.

Sincerely,

JOHN K. WEBB, Major, MC.

(From Major T. D. Dotterer, Somewhere in England)

I want to answer your important letter of 22 November 1944. We appreciate the interest you fellows back in dear old South Carolina are showing in us and in our welfare when we come home. I think of you people every day and sometimes wonder what you think of us who have pulled up stakes and live in a different world. Thank goodness I am one who thinks that you are doing a good job because I know both sides since in the First World War I was a civilian and I know it is hard to stay at home when nearly everyone is in the Service. I would not take anything for my Army experience because I shall return a better doctor and I must say better pediatrician although I have not touched a baby in thirteen months.

Our hospital is a busy place as you can imagine. The location is ideal, and with the exception of about two months we have the most beautiful flowers, trees, and meadows. When weather permits we take lovely walks daily when not rushed and shoe leather is worn out rather than rubber.

Besides being Chief of the Communicable Disease Section I am Hospital Inspector, which gives me quite a varied program. Have seen some fine men and especially my boys from South Carolina. There is not a day that passes that I do not see some patient from home.

The Ten Point Program is good and I think that you fellows have done a good job and have really accomplished something.

I shall not comment on all ten points but I think numbers 2, 4, and 10, interest me more and they are the ones which concern me. I am particularly anxious for the poor to have better medical care and I think through No. 10 this can be accomplished. This is so important and I have seen it work to the advantage of all. I know that you are familiar with the Columbia Children's Clinic — a model institution where men and women have dedicated their lives to children. This is the best examples of nos. 4 and 10 I may offer.

Keep up the good work, Julian, and I hope we can come home soon.

With kindest personal regards and the best of luck, I am

Faithfully yours,

Tom.

(From Lt. E. W. Masters, Somewhere in France)

I received your letter of 22 November 1944, today, and it is certainly good to hear all about your work and your program.

At present, I am taking care of a colored port battalion. Since I have lived in South Carolina all my life, I feel that I get along better in this capacity than some might. However, my whole outlook is keyed to getting back to South Carolina and to private practice.

Now, I'll try to answer some of your questions. I certainly feel that medical care in South Carolina has been inadequate. However, I feel that existing agencies plus some form of general hospital insurance can, if properly run and extended take care of the situation. That is why I think that the Ten Point Program is so good—it is being carried out by doctors who know more about medical care than anyone else. I feel that S. C. has made an excellent beginning of a program that I am sure will be successful. Of course, I am sure that at the present the actual shortage of physicians will hamper the program.

My plan for after the war is private practice in Columbia—if not Columbia, certainly S. C. As to what I expect from S. C. Medical Association—I'd say get your plan started and the foundation laid—give us returning the cooperation you've always done and that ought to be sufficient.

A few more answers to your questions—I feel that most Americans are enjoying so much the material (Monetary) gains of war that they forget about the horrors of it. I do not think that the home front is war conscious.

My opinion of the race question hasn't changed. I feel that the solution will be the movement by the colored people to other areas than the south so that there won't be such a large concentration in the south. I feel that they deserve the vote—South Carolina is way back on that—I think we ought to encourage legislation to give them the vote.

I feel that labor needs help—but it loses sight of the big picture because of its selfish aims. I feel that labor profits for much in wartime.

As to the Journal—I haven't received any copies except Oct. which my wife sent me first class. Of course, I've only had six addresses in six months overseas so it might not be the friends fault. I certainly did enjoy it, however, especially the article on distribution of hospitals in S. C.

I didn't mean to write so much—I must have a lot on my chest.

Best wishes for a good 1945.

Sincerely,

E. W. Masters

(From Major W. G. Bishop, Station Hospital,
Camp Sutton, N. C.)

Some few weeks before Christmas I received a letter from you along with your Ten Point Program. You asked my opinion of the Program with a few more questions in regards to myself. The latter I can not say much about except that I am healthy but not so happy.

I have read your Ten Point Program over closely and to be short, "I like it." If it can be carried out free from any political groups and left entirely in the hands of our Association, South Carolina will have one of the best designed, comprehensive, long-range programs known. I am with you and my colleagues one hundred per cent.

If the war continues a few more years, I am afraid South Carolina will lose a great number of doctors who once were general practitioners. I hear remarks made by some who have been in the service for several years and whose work is limited to administrative work, to the effect that they have forgotten a great deal of their medical knowledge. I am one who has been in the service for more than four years. The past two years has been only administrative work. When the war is over and I am out of the service, I will be most compelled to take a refresher course for a few months in order to prepare myself for the future duties as a general practitioner. Myself, along with several hundred others will not be financially able to do so, for we have "lived in the red" for the past two years. Personally, I have dropped insurance premiums in order to stay out of debt. Now, with the high cost of living, where would we be if we had to refresh six months even though the schooling costs nothing. I believe, a few of these older fellows who have been in the service four years or more, will be compelled to take a salaried job rather than to go back to general practice.

We have a great number of younger doctors in our state who have been declared essential. Why not start some kind of program in which a rotation could be set up? I hear a few of them make remarks that they would like to get into the Army but could not because they were declared essential at home; well, we know that there is a shortage on the home-front just as bad, if not more so, than in the service. Now don't you think it would be fair to give these younger fellows a chance to serve their country and let the older fellows come back and get started again on their life's career before a great number will develop a "fear" of ever wanting to do general practice again?

I noticed in the December 31 A. M. A. that the Army is going to reduce the Medical Corps. Have you any information of this? If so, I would like to know as no one seems to know anything about it in the Army.

I didn't mean to write anything but an acknowledgment of your letter, so don't let these thoughts take up too much of your time.

Best wishes to you and the South Carolina Medical Association in carrying out your Ten Point Program.

Cordially yours,

W. G. Bishop



From where I sit by Joe Marsh

Definition of a Great Man

At Bill Webster's the other evening, we were kidding Bill about his children always saying that their pop's "a great man." Dr. Walters came to Bill's rescue.

"The kids are right," chuckles the doctor. "Everybody in America's a great man. You just can't be part of greatness and not share in it."

In America (he argues) things that used to belong only to the great are common property; a share in government through the right to vote; individual liberties guaranteed by constitution; freedom to speak one's mind; to work at what one pleases; to choose what one likes to eat or drink . . . whether beer or buttermilk.

But from where I sit, there's one important point to add . . . to make the doctor's definition ring true. We must be worthy of this greatness. We must have the humility to appreciate these blessings . . . never abuse them with intolerance, intemperance, or indifference.

Joe Marsh

SOUTH CAROLINA MEDICAL ASSOCIATION
BALANCE SHEET
 December 31, 1944

ASSETS	
Petty Cash	\$ 10.00
Bank—Guaranty Bank & Trust Co.	2,814.13
Accounts Receivable	1,058.41
Deposits Receivable	3.00
Investments:	
Defense Bonds	\$ 6,500.00
Peoples Fed. Sav. & Loan Assn.	500.00
Office Furniture & Fixtures	1,100.00
Ten Point Program	3,000.00
Total Assets	<u>\$14,985.54</u>
LIABILITIES	
Social Security	\$ 7.50
Victory Withholding Taxes	118.80
Total Liabilities	\$ 126.30
SURPLUS	
Balance—January 1, 1944	\$11,403.22
Excess of Revenue over Expense	3,456.02
Total Surplus	14,859.24
Total Liabilities and Surplus	<u>\$14,985.54</u>

We have examined the treasurers records of the South Carolina Medical Association for the year ended December 31, 1944, and,

We certify that in our opinion the above Balance Sheet and accompanying Statement of Revenue and Expense sets forth the financial condition of the South Carolina Medical Association as at December 31, 1944, and the results of its income and expense for the year ended on that date.

JAILLETTE & OULLA
 Public Accountants

Florence, S. C.
 January 25, 1945

TEN POINT PROGRAM
SOUTH CAROLINA MEDICAL ASSOCIATION
 December 31, 1944

ASSETS	
Bank—South Carolina National	\$ 6,135.81
Office Furniture & Fixtures	112.50
Total Assets	<u>\$ 6,248.31</u>
LIABILITIES	
Withholding Taxes	142.80
Social Security	13.86
Total Liabilities	156.66
Advances—S. C. Medical Association	3,000.00
SURPLUS	
Excess of Revenue over Expense	3,091.65
Total Liabilities and Surplus	<u>\$ 6,248.31</u>

We have examined the books and records of the Ten Point Program, of the South Carolina Medical Association for the period May 1, 1944 to December 31, 1944, and,

We certify, that in our opinion the above Balance Sheet and the accompanying Statement of Revenue and Expense, sets forth the financial condition of the Ten Point Program as at December 31, 1944, and the results of its income and expense for the period on that date.

JAILLETTE & OULLA
 Public Accountants

Florence, S. C.
 January 25, 1945

SOUTH CAROLINA MEDICAL ASSOCIATION
STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS
 January 1, 1944 to December 31, 1944

Balance in Bank—January 1, 1944:

Guaranty Bank & Trust Company	\$ 2,836.55
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Revenue Receipts:

Membership Dues	\$ 4,666.00	
Subscription Dues	2,060.25	
Advertising	5,172.87	
Cuts in Journal	22.66	
Interest Earned	134.69	
Withholding Taxes	505.20	
Accrued Interest	21.56	12,583.23
Gross Receipts		15,419.78

Disbursements:

Audit	60.00	
Convention Expense	697.48	
Dues & Subscriptions	14.00	
Heat, Lights, Fuel & Water	30.39	
Insurance	12.90	
Miscellaneous	107.02	
Office Supplies	381.22	
Printing	3,495.84	
Rent	303.00	
Salary—Secretary & Editor	2,100.00	
Salary—Stenographer	900.00	
Postage	80.00	
Taxes & License	30.00	
Telephone	114.49	
Travel Expense	153.00	
Bank Charges	2.78	
Historical Committee	50.00	
Cuts in Journal	46.33	
Expense—Secretary & Editor	22.00	
Investments:		
Defense Bonds	500.00	
Ten Point Program	3,000.00	
Withholding Taxes:		
Social Security	\$ 30.00	
Victory Tax	475.20	505.20
Total Disbursements		12,605.65

Balance per Bank—December 31, 1944	\$ 2,814.13
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TEN POINT PROGRAM
SOUTH CAROLINA MEDICAL ASSOCIATION
STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS
 September 1, 1944 to December 31, 1944

Receipts:

Contributions	\$ 5,464.09	
Advances—S. C. Medical Association	3,000.00	
Withholding Taxes	192.80	
Social Security	19.02	
Total Receipts		\$ 8,675.91

Disbursements:

Office Expense & Supplies	253.78	
Office Furniture & Fixtures	112.50	
Travel Expense	211.27	
Salary—Executive Director (4 months)	1,666.67	
Salary—Stenographer (4 months)	235.00	
Taxes	5.16	
Bank Charges	.56	
Withholding Taxes	50.00	
Social Security	5.16	
Total Disbursements		2,540.10

Balance per Bank—December 31, 1944	\$ 6,135.81
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AERO SAKOS

It's an amazing insight into human endurance when one writes column after column of "brilliant" stories and receives, not one word of commendation—or condemnation. Aren't there any physicians in this state able to write? And incidentally we will be g'lad to print your stories. What we need is new blood in the same vein.

And speaking of newness reminds us of the story of Sammie and the teacher. It seems that the teacher reached up to pull a window shade down and several of the boys softly laughed. She turned to the first one and asked the reason. He replied, "I saw one inch above your knee." For that remark the boy was dismissed from school for one week. The second boy, when asked why he laughed replied that he saw two inches above her knee. For that remark he was sent home for two weeks. The teacher noticed that Sammie was getting his books together and leaving the class. "Why are you leaving?" the teacher asked. Sammie replied, "I saw enough to be sent home for the rest of the year!"

Of course, all of us aren't that smart or observant as witness the story told on a Governor of a neighboring state. While visiting the state prison, the governor was moved by the mournful music played by one of the inmates. It seems that this particular prisoner had been confined in the penitentiary for two years and being very homesick was pouring his heart out with the song "Home Sweet Home." After talking with the officials the Governor arranged for the inmate to visit his home. This was done and on the next inspection tour the Governor again met the prisoner. This time his tone of music was just as mournful but he was playing a different song. The Governor asked the name of the song and the reason. The Prisoner replied that when he came to prison he left one wife and one child at home but when he visited them he found one wife but two children. The name of the song? Oh, thats ca'led, "Who been dar since I been gone!"

DEATH

Major F. R. Lawther, Chief Surgeon at Kelly Field, Texas, was killed in a plane crash over Arizona in January. Before he entered the Army in June, 1942, Dr. Lawther was in charge of the Berkeley Hospital at Moncks Corner. He was graduated from the New York University College of Medicine in 1934 and interned at Roosevelt Hospital. Dr. Lawther is survived by his widow and two sons, who were with him at Kelly Field, his parents, Mr. and Mrs. Tom Lawther and two brothers of Wilmington, N. C.

BIRTH ANNOUNCEMENTS

Born to Major and Mrs. George T. McCutchen (Columbia) on January 20th, a son. Major McCutchen is stationed at Fort McClellan, Alabama.

Dr. and Mrs. Herbert Dove of Columbia have announced the birth of a daughter on January 10th.

Dr. and Mrs. G. R. Laub of Columbia have announced the birth of a daughter, Eleanor Catlin, on January 18th.

Effective Convenient Economical

THE effectiveness of Mercurochrome has been demonstrated by more than twenty years of extensive clinical use. For professional convenience Mercurochrome is supplied in four forms—Aqueous Solution in Applicator Bottles for the treatment of minor wounds, Surgical Solution for preoperative skin disinfection, Tablets and Powder from which solutions of any desired concentration may readily be prepared.

Mercurochrome

(H. W. & D. brand of merbromin, dibromoxymercurifluorescein-sodium)

is economical because stock solutions may be dispensed quickly and at low cost. Stock solutions keep indefinitely.

Mercurochrome is antiseptic and relatively non-irritating and non-toxic in wounds.

Complete literature will be furnished on request.



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REPORTS OF COMMITTEES S. C. MEDICAL ASSOCIATION

THE REPORT OF THE COMMITTEE ON POST - GRADUATE ACTIVITIES OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

It is to be regretted that war-time restrictions have forced the curtailment of much needed medical meetings. There, however, are meetings that are essential in war-time, if medical care offered the general populace is to keep pace with research workers. As early as possible, the Annual Meeting of the South Carolina Medical Association should be held on an expanded scale, not for the social and political aspects but from the viewpoint of dispensing medical knowledge. The South Carolina Medical Association should not only strive to hold the best clinical program possible, but should encourage the Piedmont Seminar and the Pee Dee meeting, at Bennettsville, by actually helping to defray a large part of the expenses. More and more the physician of South Carolina should be offered the finest in medical and surgical papers at convenient places and dates.

I. Expansion Program of the Medical College

The Committee views with great satisfaction the proposed Expansion Program of the Medical College of the State of South Carolina. The successful completion of this entire program is a "must," and it is the duty of every thinking physician in this State to lend his every effort to furthering this project. The new hospital proposed is absolutely essential. Space for teaching and an opportunity for research work must be provided. Students need the proper inspiration to "observe and record," and this can only be given by increasing the research work at the Medical College.

II. The Appointment of Dr. C. Fred Williams as the Head of the Ensor Research Foundation of the South Carolina State Hospital

The appointment of Dr. C. Fred Williams as the Director of the Ensor Research Foundation at the South Carolina State Hospital is a master stroke. A man of international prominence, past President of the American Psychiatric Society, Dr. Williams more than fills requirements to successfully accomplish his job. Thirty years as Superintendent of the State Hospital have convinced him that more than ever research in mental diseases must be carried on in an ever expanding scale, if the challenge of the mentally sick is to be met and conquered. It is his ambition to raise a sufficient sum of money as an endowment, free of political influence and guaranteeing an adequate income regardless of economic reverses of the future, that the research work at the South Carolina Hospital be assured forever. Under Dr. Williams' guidance the first and only laboratory

in the South for experimental work in mental diseases was constructed several years ago. This Committee wishes Dr. Williams every success in his new appointment and congratulates him on a long and successful career. His humane attitude, the spotless record of the State Hospital, the modern approach employing all advances in psychiatric medicine have endeared him to every citizen in South Carolina.

III. The Continuation and Expansion of the Refresher Courses of the Alumni Association of the Medical College

The Committee endorses wholeheartedly the program of the Alumni Association of the Medical College and urges their continuation even under war-time conditions. Not only is it an inspiration to the doctors but it is also stimulus to the faculty. It tends to bring the medical school and students in contact with the best medical thought of the time. Departmentalization will probably become a necessity. This idea was experimented with in November of 1944 when an intensive two-day E. E. N. T. course was given at the same time as the regular medical refresher course. It is hoped this year to have a four-day course in both fields. There is a strong possibility that the American College of Surgeons may hold its Regional E. E. N. T. meeting in Charleston and combine it with the efforts of the Alumni Association. National recognition of this type would be of tremendous help and would practically guarantee permanent success of our program. Every effort should be made to encourage such recognition wherever possible.

IV. A Look to the Future

(A) A school of tropical medicine and public health

(B) A center for continuation of study

(C) Re-education of the returning veteran

As we near the successful end of a terrible world conflict and see around us the tremendous rehabilitation problems we lift our eyes to medical horizons. We see the opportunity for the establishment of a medical center in Charleston, of which all South Carolinians could be justly proud. A school of tropical medicine in combination with a school of public health, and a center of continuation of the study of medicine are possibilities within the easy reach of our profession. Such a center would go a long way towards the goal of reeducation of the returning medical veteran and will practically guarantee post-graduate medical education for all physicians in South Carolina.

A program of this type calls for men of vision and courage. South Carolina has these men and it

is their duty to erect this work.

Respectfully submitted,

Strother Pope, M.D., Chairman, Columbia
George R. Wilkinson, M.D., Greenville
William P. Turner, M.D., Greenwood
John R. Young, M.D., Chester
Lesesne Smith, Sr., M.D., Spartanburg

REPORT OF COMMITTEE ON MEDICAL EDUCATION

The members of the Committee on Medical Education have interested themselves in actively supporting the Ten Point Program of the Association as it was recommended by the Council and adopted by the House of Delegates in Columbia last year. The well to do patient can pay for medical and hospital care, the indigent patient has them furnished by the city or by the state, but the great working class of people whose limited income provides but little more than a livelihood are unable to pay for medical and hospital bills unless payment is made from a common fund composed of small monthly contributions from a large group of individuals. This is to be done under the Blue Cross, a national non-profit making organization, already in successful operation in many states, which enables people of small incomes without undue hardship to provide for themselves medical and hospital care.

The committee urges all members of the Association to give every assistance to President Kenneth M. Lynch and the Board of Trustees of the Medical College in their efforts to provide more adequate facilities for the teaching of medicine in South Carolina. Medicine, unlike the other professions, may not be learned from books and academic teaching alone. Well equipped laboratories are essential. Clinical medicine can be learned only from the study of clinical material. Patients to be available for teaching purposes must be hospitalized. It is mandatory that the State build and equip a hospital in Charleston of sufficient size to provide for the clinical needs of the College. South Carolina for the first time in its history has a surplus and is able, with Federal aid, to do this. After the war the Federal Government will appropriate vast sums for loans to industry and for public works to provide jobs for the millions of men who will soon be discharged from the armed forces.

This is a cause worthy of our active and our united support.

Respectfully submitted,

George H. Bunch, Chairman.

REPORT OF LEGISLATIVE COMMITTEE

Mr. President and Gentlemen of the House of Delegates.

Dear Sirs,

As chairman of your Legislative Committee I hereby submit a report of its activities. At this

time the Legislature is still in session and other matters pertaining to the Medical Association may come up. We are keeping in close touch with matters and will be active in anything pertaining to the Medical Association.

Dr. Pitts and I attended a luncheon at meet with the Blue Cross Hospital group and discussed a proposed bill and later to appear before the Senate Medical Affairs Committee and urge this committee to introduce this bill as a committee bill. The Blue Cross Hospital group needs an enabling act to allow it to establish a non-profit insurance. The Medical Association was included in the act. Our committee thought it best for the good of all concerned not to include the Medical Association in this bill at this time. It was introduced as a committee bill and has had smooth sailing so far in the Legislature.

Your committee also appeared at a hearing before a joint committee of the House and Senate in relation to the Marriage Bill. This bill has been changed by the Legislature from its original form and at present it looks as if some form of the Marriage Bill will be passed.

Respectfully submitted,

N. B. Heyward, M.D., Chairman

REPORT OF THE BOARD OF MEDICAL EXAMINERS

Mr. President and Gentlemen of the House of Delegates:

The Board of Medical Examiners submits the following report:

Licensed by Examination during 1944	97
Licensed by Reciprocity	13
<hr/>	
Total licensed	110
Failed	1

Respectfully submitted,

S. C. Board of Medical Examiners

N. B. Heyward, M.D., Sec.

REPORT OF THE DELEGATES TO THE A. M. A.

To the House of Delegates of the S. C. Medical Association

Gentlemen:

The 94th annual session of the House of Delegates of the A. M. A. convened in the Palmer House in Chicago, June 12, 1944. This city was again chosen in which to hold the meeting due to inconveniences of travel and its more or less central location. Travel to and from the convention city was far from pleasant, and far from the luxuries and conveniences of pre war travel. Food was a problem during the entire sojourn and journey.

Speaker H. H. Shoulders of Nashville, Tennessee, called the House to order promptly and there were 150 delegates at the opening.

The choice of the recipient of the distinguished service award was one of the first transactions. The choice was between Dr. Isaac Abt, of Chicago, Dr. George Dock of Pasadena, California, and Dr. Simon Flexner of New York. Your delegate voted for Dr. Abt since he has often been in our state and too, Dr. W. M. Weston of Columbia. Dr. Mulheman of Augusta, W. C. Davidson of Duke, and Dr. Julian Price of Florence, all Pediatricians had asked my support of their colleague. Dr. Dock was the recipient of the award.

Speaker Shoulders made a forceful address calling for serious consideration of all matters submitted and named reference committees. The work of the House of Delegates is accomplished via these committees. (Only a small percent of the delegates are appointed to serve on reference committees, and it was an unexpected complement to our State and to your delegate that I was placed on the "Reports of Officers" committee.) Dr. Shoulders called attention to attacks from various sources on American Medical practice and I quote, "I call attention to this challenge for the purpose only of emphasizing again that the proponents of radical change are as clever, persistent, and deceptive as they are fundamentally unsound," end quote.

Next was an address by President James E. Paullin of Atlanta, Georgia. He thanked the House for the honor they had given him. He spoke of the success of the post graduate instruction of physicians in the armed services and what a success it had been.

The supply of medical students is seriously affected by the directive of Selective Service, he cited. Canceling deferments of pre-medical students. (This has not been corrected at this writing.) President Paullin made a plea for close cooperation of all medical men to maintain medicine on a high standard. He pointed out that one need for better medical care at a lower cost was the finding of a survey made for The National Physician Committee, and said that sickness insurance, either compulsory or voluntary, was a possible means of accomplishing this. The speaker received a resounding ovation at the end of his address.

President Elect Herman L. Kretchmer was the next speaker. He spoke of the work of the Board of Trustees of the A. M. A. with his praise. (This body is the most powerful body in organized medicine.) He praised the National Physicians committee as did all of the high officers of the A. M. A. (The N. P. C. was in greater favor than was previously thought.) He reported, however, that only a little over 6,000 doctors out of the 160,000 in the United States had made contributions. The speaker rapped the lack of teaching of drug therapy in our medical

schools. He urged that medical programs in general, should be directed toward things of interest to general practitioners.

A resolution asking the President of the United States and Congress to correct the drastic Selective Service Regulations, with reference to prospective medical students, was adopted.

The newly created council on Medical Services and Public Relations reported there was a further attempt to unionize hospital employees despite a Federal Court ruling that, "a hospital is not an industry."

There was considerable comment on the statement of Dr. Martha Elliott in certain circulars dealing with the E. M. I. C. program that were not too complimentary to the medical profession.

Having received instructions from this body to introduce a resolution dealing with a change of constitutions by laws of the A. M. A. so that there would be a minimum of two delegates from each state (the full text, as introduced, appears on Page 583 of the A. M. A. Journal in June 24, 1944 issue.) The resolution was referred to the proper committee. Julian Price and myself each spoke in favor of it at the hearing. We were not very effectual as it received a unanimous disapproval from the committee which assures its death when it is voted upon at the next session. It was gratifying to find good support from the delegation of North Carolina, Georgia, and some from New York, all our neighbor states; and too, generally from the smaller states, but there was no consideration from the real powers. A similar resolution was introduced by Dr. E. N. Roberts of Idaho.

Several resolutions were considered in Executive session, one from the National Medical Association (negroes) seeking close cooperation. Another was by the California delegation seeking to make drastic changes with the Secretary of the A. M. A. and the Editor of the Journal. There was parliamentary activity, masterful maneuvering, and a little shinigan by the powers. One of the very clever moves (right or wrong) was to have the Editor appear in person and make a statement. He put on a good act—that of a martyr. The upshot of the whole thing was voted down and what was launched as an attack resulted in a blanket vote of confidence.

The Meeting of June 13, 1944—the House of Delegates refused to pass a resolution creating a Board of General Practitioners. There was an emphasis on the desirability of providing scientific papers of interest to general practitioners, in all societies.

The committee on Hygiene and Public Health supported a resolution dealing with the teaching of Health Education and Biology in secondary schools. It was passed unanimously.

The House adopted a resolution again requesting Congress to create a National Department of Health

and to have at its head a cabinet officer. There was also a resolution requesting the transfer of the E. M. I. C. Program to the U. S. Department of Health.

A Resolution on Tuberculosis control which would place a large part of this activity under the Federal Security Administration was killed. Thursday P. M., June 15—General David N. W. Grant (well known to South Carolinians) made a splendid talk on "Combat Fatigue and its Care." He also talked on many topics of wide interest. General Grant said that psycho-neurosis was not as much a problem as some would have you believe.

Surgeon General Norman Kirk followed General Grant with an address. He differed definitely and semi-violently with General Grant on the subject of psycho-neurosis, and one could sense friction. In the end it seemed that the first speaker had been better received.

Dr. Roger I. Lee of Boston resigned from the Board of Trustees and was elected President Elect. Dr. Louis H. Bauer of New York was elected to the Board in place of Dr. Lee.

The 1945 session (now canceled) was to be held

in New York, the 1946 in San Francisco, and the 1947 meeting in Atlantic City.

The reapportionment of delegates will take place at the next meeting (every third year). South Carolina can have two delegates if there is a total paid membership great enough, possibly less than 100 more than last year.

One of the outstanding things to me was the high percentage of attendance. There were 169 of the total 175 delegates present on the 13th. This shows the interest in this organization. It is the leading Medical organization of the world. It is reserved, deliberate, and cautious. The principals laid down are sound and made only after a thorough consideration. This organization is however somewhat staid, rule bound, and there is little chance of it changing.

The experience of representing South Carolina has been rich and I have enjoyed it. I have made many friends from over a wide area. I want to again express my sincere thanks for the honor and the privilege.

Respectfully submitted,
Thomas A. Pitts, M.D.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. William H. Folk, Spartanburg, S. C.

Publicity Secretary: Mrs. J. C. Josey, Spartanburg, S. C.

The Edisto Medical Auxiliary held a delightful meeting recently at the home of Mrs. Vance W. Brabham on Moss Heights, Orangeburg, South Carolina. A turkey luncheon was served buffet style from a beautifully appointed table in the dining room.

After luncheon, Mrs. Brabham presented the speaker of the afternoon, Mrs. William H. Folk, of Spartanburg, President of the Woman's Auxiliary to the South Carolina Medical Association. In an interesting manner Mrs. Folk spoke to the doctors' wives urging them to make their lives count by using their contacts with the medical world for the welfare and health of the general public. In relation to public health, the speaker talked specifically of the cancer control movement, which is one of the primary interests of all medical auxiliaries at the present time.

Colonel Howard J. Hutter, post surgeon at Camp Croft station hospital, was guest speaker at the luncheon meeting of the Woman's Auxiliary to the Spartanburg County Medical Society at the Cleveland Hotel. He gave a report of the medical setup at the Mediterranean base section in North Africa beginning with December 8, 1942.

Wives of Camp Croft physicians were guests. Also present were Major Clyde J. Ellison and Captain E. J. Dieter, of the Hospital unit.

A musical program was given by Byrd Austell

Thompson, accompanied at the piano by Grigg Fountain.

The luncheon table was arranged in a large U and decorated to commemorate the harvest season. Mrs. H. W. Koopman, president of the Auxiliary presided and introduced to the guests Mrs. William H. Folk, President of the Woman's Auxiliary to the South Carolina Medical Association who urged the Auxiliary members to continue their work on behalf of the physical fitness program, cancer control and prevention of juvenile delinquency. Mrs. Folk was presented a gift by Mrs. Koopman on behalf of the auxiliary in appreciation of her work as State President.

Colonel Hutter, an army medical officer since 1917 returned to the States from the Philippines in 1940 and activated the 58th medical battalion. In 1942 he went to England where he was assigned Mediterranean base surgeon with entire charge of the medical setup in the North African area. In his address he told in detail of the work of choosing hospital sites, caring for the evacuation of the sick and wounded, maintaining medical supplies and establishing sanitation in North Africa.

At the conclusion of Colonel Hutter's address dozens of pictures were shown on a slide by Captain Dieter depicting scenes of the 64th station hospital, 180th general hospital and surrounding details, including the supply depots in Oran and Sidi-bel-abbes.



WHEN NUTRITION MUST BE MAINTAINED

Few are the diseases in which maintenance of the nutritional state is less important than specific therapy. For unless the metabolic demands of the morbid organism are adequately satisfied, maximal response to drug administration hardly can be expected.

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The Journal of the South Carolina Medical Association

APRIL, 1945

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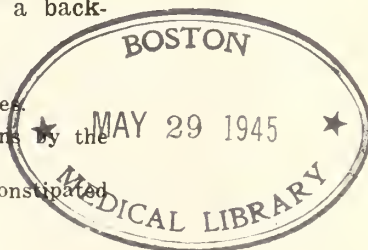
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The Surgical Management of Thrombophlebitis and Phlebothrombosis of the Lower Extremities

H. G. SMITHY, M.D., CHARLESTON, S. C.

From the Department of Surgery, Medical College of the State of South Carolina, and the Roper Hospital, Charleston, S. C.

Venous obstruction from intravascular clotting occurring in the lower extremities can be classified into two principal categories depending upon whether or not an inflammatory element accompanies the process. Clinical and pathologic distinction should be made, therefore, between thrombophlebitis and phlebothrombosis, the former denoting inflammatory venous obstruction, the latter non-inflammatory.

THROMBOPHLEBITIS

By virtue of the anatomical arrangement of the venous circulation in the legs, thrombophlebitis may affect either the deep femoral system or the superficial saphenous system. Since the behavior of the two types is different, each will be considered separately.

Deep Thrombophlebitis — The clinical picture of acute femoral thrombophlebitis is well-known, consisting of local tenderness over the involved venous segment, fever, sometimes chills and a cyanotic extremity which shows a well-defined degree of edema. While this familiar syndrome has been recognized for years, its pathologic physiology was poorly understood until 1940, when Ochsner and DeBakey¹ contributed much toward clarifying the more obscure features of the condition. It was their contention that the edema, which develops with remarkable rapidity, was not due entirely to increased venous pressure but was influenced to a considerable extent by the presence of an associated vasoconstriction. That inflammatory obstruction of a large venous trunk can initiate reflex nerve impulses mediated

through the sympathetic nervous system is now generally accepted. Such reflexes are discharged through the lumbar sympathetic nerves and produce widespread vascular spasm throughout the affected extremity, involving veins as well as arteries. The immediate effect of vasospasm is decreased oxygen tension of the tissues incident to the stagnation of circulating arterial blood. As the degree of hypoxia increases, the capillary endothelium loses its normal function and a generalized increase in capillary permeability ensues. The result is transudation of large quantities of fluid from the vascular bed into the tissue spaces through the anoxic capillary network. The subsequent extravascular accumulation of serum proteins within the tissues seriously disturbs the osmotic balance existing between the blood stream and the tissue spaces and encourages further loss of fluid from the capillaries. This sequence of events, superimposed upon a coexisting venous obstruction, leads to the rapid development of generalized edema of the limb (Figs. 1 and 2).

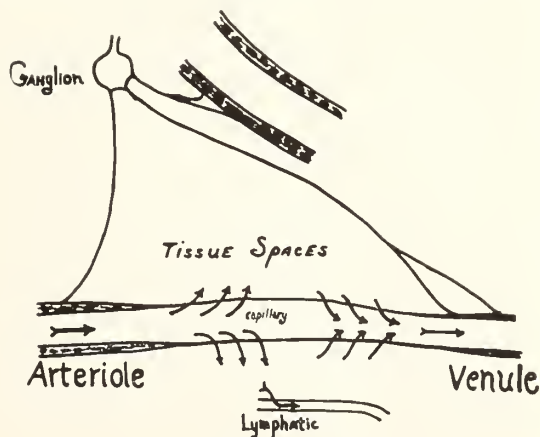


Fig. 1—Diagrammatic illustration of the normal mechanism of interchange of fluid between vascular bed, tissue spaces and lymphatics.

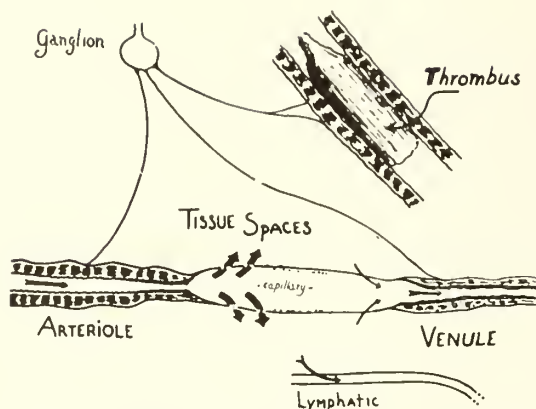


Fig. 2—Diagrammatic representation of the effects of vasoconstriction initiated by inflammatory venous thrombosis. Note discrepancy between amounts of fluid lost into the tissue spaces and amounts returning to vascular bed.

From the foregoing discussion, it follows that the primary consideration in the treatment of acute femoral thrombophlebitis is elimination of vasospasm. The distressing sequelae of postphlebitic edema, ulceration and intermittent claudication can be prevented effectively by interruption of the sympathetic nerve impulses to and from the involved extremity. This can be accomplished through novocaine infiltration of the ipsilateral lumbar sympathetic ganglia, the technique of which has been described elsewhere in adequate detail.²⁻⁴ Prompt relief from pain, a return of the body temperature to normal through surprisingly rapid subsidence of the inflammatory reaction and early disappearance of the edema follow lumbar sympathetic block. It is to be emphasized that best results are obtained when sympathetic block is done early, preferably within the first 72 hours of the onset of symptoms. Novocaine infiltration of the ganglionated chain should be done daily until the body temperature returns permanently to normal.

Discussion of the treatment of acute deep thrombophlebitis is incomplete without consideration of the problem of pulmonary embolism. With this serious complication in mind, several investigators⁵⁻⁸ have advocated ligation and division of the femoral vein in the region of its junction with the profunda femoris as a valuable measure in the prevention of embolic phenomena. While femoral ligation is an established surgical procedure, it must be considered necessarily as a radical adjunct to the therapeutic regimen in deep thrombophlebitis. An evaluation of this form of therapy involves several important questions. First, what is the actual incidence of embolism in cases of femoral venous thrombosis where the inflammatory factor is a prominent clinical feature? Estimates of the frequency of embolism appearing in the literature in the past two or three years vary considerably due probably to the fact that all types of intravascular clotting are included in the figures. Considering only those cases of deep venous obstruction associated with clinical evidence of in-

flammation, i. e., true thrombophlebitis, the over-all incidence of embolism is quite low. Homans has stated that embolism from "primary" ilio-femoral thrombophlebitis is actually rare,⁵ an impression which is corroborated by a review of the cases of pulmonary infarction coming to autopsy in the Roper Hospital.⁹ By virtue of the inflammatory reaction in thrombophlebitis, the thrombus is anchored firmly to the vessel wall and its detachment therefrom is mechanically difficult, accounting in large measure for the low incidence of embolism. An other factor which tends to minimize the advisability of routine femoral ligation is the matter of proximal extension of the phlebitis to the iliac veins. While iliofemoral involvement can be suspected, its diagnosis is by no means always possible. Even with X-ray visualization of the deep venous network after intravenous injection of radio-opaque material, the presence or absence of iliac thrombophlebitis cannot be ascertained in every instance. To attempt venous ligation above the iliac vessels is to undertake a surgical procedure of considerable magnitude, the outcome of which is unpredictable at best. In consideration of the foregoing factors relative to femoral ligation, one is confronted with the last, and most obvious, question. How effective is lumbar sympathetic novocaine block in the prevention of embolism from acute deep thrombophlebitis? Statistical data on this important matter are not available in the literature in abundant form. However, Ochsner and DeBakey (quoted by Welch and Faxon⁶) had encountered only one pulmonary infarct in nineteen patients treated by this method up to 1941. On the surgical service of Roper Hospital, fifteen cases of acute thrombophlebitis have been treated by sympathetic block in the past two years without the occurrence of demonstrable pulmonary infarction. By virtue of the remarkable rapidity with which the inflammatory process subsides following novocaine injection of the ganglia, it seems permissible to conclude that the thrombus becomes organized by fibrous tissue proliferation, which is the end-result of any inflammatory process, and is thereby fixed permanently to the vessel wall. Until statistical data can be presented to the contrary, sympathetic block by novocaine infiltration of the lumbar ganglia remains the treatment of choice in acute deep thrombophlebitis from both the standpoint of cure and the prevention of embolism.

Untreated thrombophlebitis progresses to the distressing and disabling state of chronic lymphedema and ulceration in a high percentage of instances. Treatment of the post-phlebitic state has been a major problem for many years. Inasmuch as the inflammatory process, which is thought to initiate vasoconstriction in the acute phase, is not a factor in chronic post-phlebitic edema, interruption of sympathetic impulses should be theoretically of little value. However, it has been shown¹⁰ that the flow of lymph normally depends upon substantial arterial pulsation and is directly proportional thereto.

Furthermore, the average victim of the postphlebitic syndrome exhibits abundant evidence of tissue hypoxia of the affected limb, manifested by a suffused, purplish appearance of the brawny, edematous integument. On the assumption that increased collateral circulation (and consequently increased arteriolar pulsation) as well as increased tissue oxygenation result from sympathectomy, excision of the lumbar ganglia has been performed recently in two patients having chronic thrombophlebitis on the surgical service of the Roper Hospital. The results have been completely satisfactory although not as prompt and dramatic as those produced by novocaine block in the acute phase. Subsidence of the edema and disappearance of the anoxic symptoms developed within a few weeks of the operation.

Superficial Thrombophlebitis — Acute inflammatory thrombosis of the great saphenous vein or one of its principal tributaries is of rather frequent occurrence. Accompanying signs of inflammation, consisting of redness along the course of the vein, increased local heat and a palpable swelling of the involved segment, are prominent. Pain is variable but is generally present and sometimes severe. Edema of the extremity may be a feature, but is rarely marked. The response of superficial thrombophlebitis to sympathetic block is satisfactory in every way. However, there is a tendency for the thrombus to progress in a proximal direction and invade the femoral vein. In order to prevent the development of deep thrombophlebitis, ligation and division of the saphenous vein is recommended as the treatment of choice. Prompt disappearance of the inflammatory process and gratifying relief of pain follow division of the venous trunk. Such a result is at-

tributed to interruption of the sympathetic nerve reflex by dividing the sympathetic fibers which course along the adventitia of the involved venous segment. The level of division depends upon the location and extent of the thrombophlebitis which may involve the entire vein or confine itself to segments either above or below the knee (Fig. 3).

PHLEBOTHROMBOSIS

The occurrence of non-inflammatory venous thrombosis in the legs presents a problem of major diagnostic importance. In the absence of the usually prominent signs of inflammation, bland thrombosis does not manifest its presence by subjective discomfort. Furthermore, the effects of vasospasm are lacking so that edema is seldom a prominent clinical feature. The detection of phlebothrombosis depends largely upon frequent examinations of the lower extremities in the postoperative patient. Slight traces of edema of the foot or ankle, moderate pain on deep pressure of the plantar surface of the foot, undue elevation of the pulse rate and a positive Homans' sign will afford a reasonable percentage of correct diagnoses. Of the few positive physical signs, Homans' test for pain in the calf muscles on forced dorsiflexion of the ankle is said to be the most valuable.

Pathologically, phlebothrombosis differs from thrombophlebitis in that the thrombus is not adherent to the vessel wall. In the absence of inflammation, the clot can become easily mobilized and cast off into the blood stream as an embolus. For this reason, the presence of quiet deep thrombosis first manifests itself by the occurrence of pulmonary infarction in a high percentage of cases.

The treatment of phlebothrombosis is primarily the

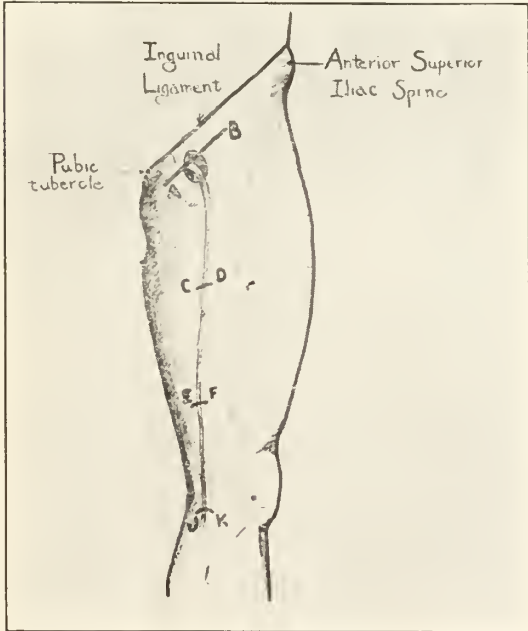


Fig. 3—Sites of election for ligation of the great saphenous vein, depending upon location and extent of the phlebitis.

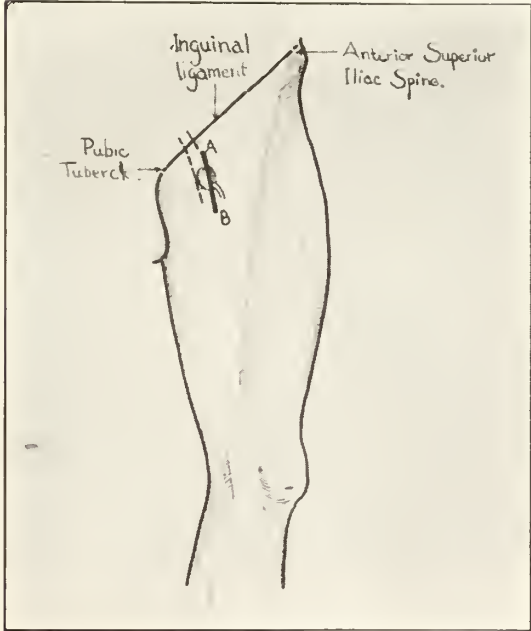


Fig. 4—Incision, AB, for ligation of the common femoral vein.

prevention of embolic disturbances. In this respect, there is no substitute for ligation and division of the femoral vein above the profunda femoris (Fig. 4).

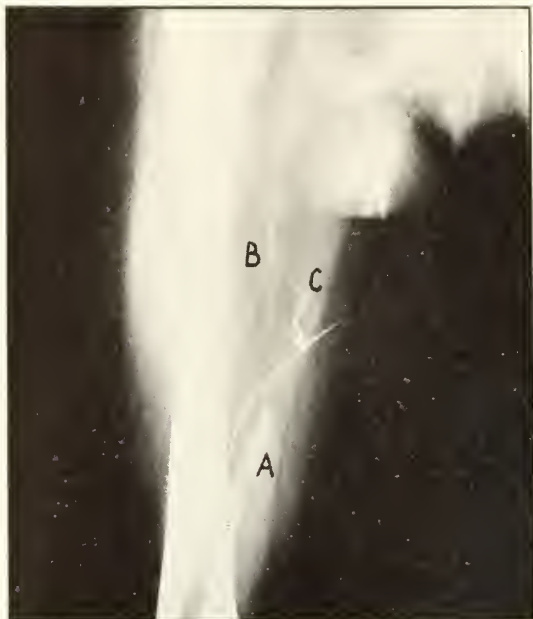


Fig. 5—Venogram showing obstruction of femoral vein from A to B, due to thrombophlebitis. Note distended communicating veins, C, from superficial system entering femoral vein above the obstruction at B.



Fig. 6—Venogram showing complete absence of filling of deep veins due to disseminated phlebothrombosis. Note tremendous number of tortuous collateral tributaries of great saphenous vein.

Once the diagnosis is definite, routine division of the femoral vein becomes a matter for serious consideration, for the consequences of pulmonary embolism may be of the gravest nature. The presence of bland thrombosis may be suspected clinically, but not confirmed, thereby raising the question as to the actual necessity of femoral ligation. Under such circumstances, X-ray visualization of the venous system, after intravenous injection of a radio-opaque substance at the ankle, will contribute much to the location of a deep thrombus (Figs. 5 and 6). Another phase of the problem is represented by the postoperative patient who suffers a non-fatal episode of embolism and yet presents no clinical evidence of phlebothrombosis. In this instance, venographic study should be made of both legs in an effort to locate the source of the embolus. Should the venograms reveal the presence of deep thrombosis, femoral ligation should be done promptly because of the likelihood of recurrent embolism and the higher mortality rate accompanying a second or third episode.

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Use of Sulfonamide-Ephedrine Nose Drops After Tonsillectomy

GEORGE R. LAUB, M.D., COLUMBIA, S. C.

Theoretically, the use of one of the sulfa preparations combined with ephedrine should be very useful after a tonsillectomy. The former cleans the operative wound and the latter causes the contraction of the blood vessels, preventing a hemorrhage this way. On the market is a series of such preparations advertised by different companies as nose drops. The writer uses Thizodrin* routinely after each tonsillectomy for more than a year. A sponge is dipped into the above mentioned solution, and thereafter put into the tonsil niches under slight pressure. The same procedure is used for tonsillectomies under general anesthesia as well as those under local anaesthesia. The latter is done with 1%

novocain solution without Adrenalin. Although sutures are used only in cases of hemorrhages from blood vessels, a relatively rare incident, only very few postoperative hemorrhages were seen. It is also remarkable that in this series of cases no postoperative infections expressed by elevation of temperature or swelling of the lymph nodes occurred.

Not working at one of the big medical centers, the number of cases observed is relatively small. However, the good results will justify further investigation of this method.

*We wish to express our gratitude to Eli Lilly and Company for furnishing this preparation.

Pregnancy Spacing in South Carolina From the Public Health Standpoint

JOHN B. NETTLES, CHARLESTON, S. C.

(Thanks to the splendid work of the Committee on Maternal Welfare of the South Carolina Medical Association (Robert E. Siebels, Chairman), South Carolina stands at the forefront of states in the field of Pregnancy Spacing.

John B. Nettles chose this subject for discussion in his graduating thesis at the Medical College of the State of South Carolina. His thesis was given honorable mention in last year's class—and we feel that it was a wise choice.

We publish this article, therefore, because it tells of the interesting and progressive work which has been carried out in this state and because it shows the type of research study of which one of our recent graduates is capable.

In a future issue of this Journal we will publish the first honor thesis which will, in turn, show what a recent graduate did in the field of laboratory research.—Editor.)

PART I

Introduction

Pregnancy Spacing from a public health standpoint varies in many respects from pregnancy spacing as conceived by the average physician or the average layman. Here we are dealing with that class of patients who ordinarily receive their medical care through public health departments rather than through private physicians. Methods used in private practice often fail in public health work because the public health patient often cannot or will not follow procedures that are simple for the aver-

age office patient.

It is the purpose of this paper to discuss the pregnancy spacing program only from a public health standpoint. Permanent means of birth control are not included; nor has any attempt been made to discuss the legal or religious aspects of contraception.

History

In July, 1935, a Committee on Maternal Welfare of the South Carolina Medical Association was formed to investigate the causes and circumstances surrounding maternal mortality and to formulate plans for its improvement. The reports of this committee brought out the fact that 25% of the women dying maternal deaths had been chronically unfit for the hazards of pregnancy by reason of preexisting disease or disability, in the opinion of a physician, before the final pregnancy began.

Among the recommendations of the committee in 1938 was the request that the House of Delegates pass an enabling resolution so that the State Board of Health would be able to give contraceptive advice and material to those patients under its care who, in the opinion of a physician, were in need of it. The resolution passed by the House of Delegates in May, 1938, directed the State Board of Health to carry out such a program through its county health units. At the regular meeting of the Executive Committee of the State Board of Health on February 15, 1939, Dr. Robert E. Siebels, Chairman of the Committee on Maternal Welfare since its inception, was authorized "to inaugurate the birth control work according to the set-up which he presented."

The following month, pregnancy spacing in appropriate cases when prescribed by a physician became an integral part of the activities of the county health units.

Each county health officer was directed to seek the approval of his county or district medical society for the operation of the program in his area, and the cooperation of the physicians serving in the various clinics. Of the 46 counties in South Carolina 30 accepted the program at its initial presentation, and 15 requested a representative of the State Board of Health to appear before them and give the plan wider discussion. The consulting obstetrician visited these counties during 1939 and 1940, and in each instance endorsement of the program followed. One county failed to endorse the program. Only after the local society approved the project was it started in any county. There has been no conflict, therefore, between the interests of the general practitioner and the county health office.

Prior to the initiation of the county health plan Charleston had a pregnancy spacing clinic. In 1935 several women canvassed local physicians and laymen in an endeavor to get a clinic started. Despite scattered opposition they secured a favorable report from the county medical association (Medical Society of South Carolina). In early 1937 the Maternal Welfare Bureau, Inc., held its first clinic.

Roper Hospital supplies the space and nurses and buys the materials and supplies, although this clinic is not a part of the out-patient department of Roper. All medical questions and policy are under the Medical Director and a Medical Advisory Board of 12 local physicians. A lay board is responsible for the salary of the social worker and for the running expenses. When the state county health plan was presented it was decided that the Charleston health unit would refer its pregnancy spacing candidates to this clinic rather than have two similar clinics in the same area. This clinic is also a referral clinic for the local social agencies and is a teaching clinic for the senior class of the Medical College of the State of South Carolina.

Need for Birth Control In South Carolina

In the case of public health patients the morbidity, and especially the mortality, associated with pregnancy is essentially due to pregnancy complicating a pre-existing disease or abnormal condition rather than to disease complicating pregnancy.

Contraceptive problems, like other obstetrical problems, are closely tied up with inadequate housing, improper eating habits, insufficient medical care and low incomes. These are not improved by the philosophy of poverty and the apathetic attitude of the average public health patient. Few of us realize the conditions under which the "poor white trash" and the negro exist in this state. Many of them actually consume such inadequate diets that the state of nutritional edema, secondary anemia and poor re-

sistance often actually endangers their lives. Such women are not fit candidates for the added burdens of pregnancy.

Most of our maternal mortality and much of our maternal morbidity occurs in those unfit for pregnancy. The Committee on Maternal Welfare of the South Carolina Medical Association in 1938 reported that 25% of our maternal mortality occurred among those chronically unfit for the hazards of pregnancy by reason of pre-existing disease or disability, with or without malnutrition. In each case pregnancy had been advised against by physicians before the fatal pregnancy because of reasons sufficient to warrant sterilization or, should the patient conceive, a therapeutic abortion early in the course of the pregnancy. Many of such patients represent cripples from repeated, frequent or complicated pregnancies, improper diet, tuberculosis, heart disease and severe anemia. It is of interest to note that these chronic unfits in 1938 left motherless 384 children under 15 years of age, many of them syphilitics and all adding to the health department load. Surely these patients should have had contraceptive advice and materials.

Active syphilis in either a husband or a wife is a definite indication for contraception until the disease is brought under control. About 25% of the patients in prenatal clinics in South Carolina are under treatment for syphilis.

The question for the need of contraception in mental and nervous cases, temporarily or permanently, presents a special problem and each case must be given special attention.

Multiple pregnancies at close intervals is a definite threat to the lives and health of public health patients. Almost all postpartum hemorrhage deaths occur in this group. In 1940-41, of the 19 cases of maternal deaths considered chronic unfits before their final pregnancy 17 had had 5-19 pregnancies at close intervals (in most cases), and two were chronic cardinals.

Cardio-renal diseases are frequently sufficient to demand that the patient not become pregnant.

Special hazards of pregnancy are presented by the employment of women in industry, such as weight lifting, standing and exposure to toxic fumes. While in some cases these may be indications for the temporary use of contraception they are primarily problems of industrial health.

The medical profession is not in the position to say how many children a given income will support or should support, but it is concerned with maintaining the health of the mothers and preventing further damage to her organs by what means it has at its disposal.

The conscientious physician can no longer be content with telling the patient that "she must not get pregnant again as it will probably cost her her life" but must take the next step and prescribe an inexpensive and non-irritating method which she is capable of using: an extension of this program

should have a place in all welfare clinics as well as in private practice.

Organization of the Pregnancy Spacing Program

The pregnancy spacing program in South Carolina has two objectives:

First. To provide adequate contraceptive material to such patients for whom it may be prescribed by a licensed physician, and for such time as is indicated.

Second. To test the acceptability and the efficiency of such material as may be approved by the consulting obstetrician.

The purpose is to make the clinics accessible to the patient of the low or no income group, and represent to her the type of advice and treatment that the well-to-do patient obtains from her physician. There are no distinct "birth control" clinics under the public health program, and none are planned. The patients receive such aid when they need it and the prescription for their receiving it may be written by the physician conducting the tuberculosis clinic, a well baby clinic, or any other activity. Thus an attempt has been made to *integrate* pregnancy spacing into the public health program.

This service is a part of the general clinic service rendered by county health units. Those patients able to pay for material are directed to the drug store to purchase it, just as those able to pay for medical service are directed to their family physician. The only exception is when the local druggist does not wish to stock the material, and then the county health unit furnishes it with the full knowledge of the druggist.

A patient may be referred to the clinic by any person or agency, just as any patient suspected of having tuberculosis may be referred to a clinic; in the latter case the fact that she has been referred to a clinic does not necessarily mean that she will be sent to a sanatorium, so in this program she may not receive contraceptive advice unless the physician feels it is indicated.

Through the generosity of the Birth Control Federation of America, Inc., funds were provided to pay the salary and traveling expenses of a registered nurse, trained in contraceptive technique, who was loaned to the State Board of Health. This "consultant nurse in pregnancy spacing" was under the general supervision of the department heads in the central office in Columbia which deals with all phases of the public health program, but more directly was under the supervision of the consultant obstetrician. At the request of local medical societies and the county health officer, she visited the county units to instruct the personnel in the proper securing and keeping of records and the technique to be followed.

The Birth Control Federation of America, Inc., has cooperated well. They have given valuable aid and have exhibited an understanding and sympathetic attitude toward this program. They have not tried

to influence the procedures in any way. Their attitude has been "call on use and we will help you in any way that we can, but you will have to ask us."

Much of the success of such a program as this depends on securing the cooperation of physicians, midwives, and others coming in contact with potential users of the service.

At the start of the program each county health unit requesting it was furnished with twelve units of contraceptive material at no cost to the unit to begin the program: this material cost 40 cents per unit and it is estimated that three units are sufficient for a year's supply. It was suggested that the patient be charged 50 cents for the material, the extra ten cents to go into a small fund with which to take care of those completely unable to pay.

The policy of the pregnancy spacing program is not a reduction of population, but better babies, and lower mortality for babies and mothers. In carrying out this program there is a significant improvement in the general health of those women who have borne children.

Records

The records kept in a pregnancy spacing program should be sufficiently adequate to enable the health officer to know how useful the program is and whether or not the material he is using is satisfactory. Where the "family folder" system is in use there are merely additions as in the case of venereal disease treatment or some other service.

The records should include such general information as would be helpful in any program—name, date, age, address, race, religion, occupation, family history, marital history, menstrual history, medical history, surgical history and a general physical examination. The physical examination should give in detail any condition which in itself constitutes an indication for pregnancy spacing. In addition certain other data is necessary for a good record.

The records must give full details of the patient's economic and social background, the reason for the giving of the material, and a check on the material to determine its usefulness.

The dates of the patient's previous deliveries and miscarriages are noted to aid in deciding if the contraceptive is preventing pregnancy for a longer time than the patient has previously gone with exposure.

The date of the last period should be noted at the time the patient is furnished the material in order to prevent the assumption of "method failure" when pregnancy is reported, in spite of use of the materials.

An important part of the record is the length of time the material is to be used, for once the contraceptive is no longer indicated the case becomes a "closed" one.

Room should be included on the record for follow-up notes. These should include the results, the reaction of the patient to the method and any pertinent comments.

Another detail, less obviously important to many, is directions on how to reach the home of the patient, especially should she live in a remote area. It is also important that Wassermanns be taken unless a negative test has been received within the past year.

The material used and the amount supplied should be noted, as well as the estimated date refills will be needed.

In the presence of chronic infections the contraceptive materials are often highly irritating. Therefore the examiner should look for evidence of infection should the patient complain of irritation from the material.

The county health officer has the necessary forms typed, mimeographed or printed. The forms vary somewhat in different units.

Statistical Methods

At first glance the methods used in an analysis of the value of contraceptives appear quite complicated, but no other method has been evolved for measuring effectiveness on a large scale accurately. The reduction in fertility is determined from the pre-clinic pregnancy rate and the postclinic pregnancy rate.

The preclinic pregnancy rate is based upon the number of preclinic pregnancies and the number of months of exposure to pregnancy. Since many of the public health patients have not had benefit of parson for many of their exposures the number of months of preclinic exposure is dated either from marriage or from the date of her first conception, whichever is longer, up to the date when she was supplied with contraceptive materials. The total of the months of all patients in the unit divided by the number of pregnancies in the preclinic period, multiplied by 100, indicates the rate of pregnancies per 100 "woman years" of preclinic exposure.

The postclinic rate is found by dividing the total number of pregnancies in the postclinic period by the number of months under clinic observation.

The reduction in fertility is found by multiplying the postclinic rate by 100, dividing by the preclinic rate, and subtracting the result from 100.

These results give the composite evaluation of the benefit from the reduction of pregnancies in the group, and is a measure of such factors as the co-operation of the patients, the efficiency of the field workers and the preventive value of the several methods. Thus it is not purely an evaluation of the material as a pregnancy preventive in any particular case.

Methods and Materials Used

It is generally accepted that contraceptives must be certain, simple, harmless, not unpleasant—easy to get, easy to keep, easy to use, and easy to discard after use. Because the woman is more likely than the man to faithfully carry out the method of control, the means may better be in her hands. In pri-

vate practice, and with some clinic patients, the diaphragm-jelly method is considered preferable, and, when properly used, gives excellent results. The average public health patient either cannot or will not use this method properly. For such a patient simpler methods must be used, together with strong attempts to get her to understand the method used and to cooperate.

The two simple methods most useful in public health clinics are the sponge and powder method (foam sponge method) and the jelly alone method. These materials should have a place in all welfare clinics as they give as good results as the more expensive methods in the majority of public health cases. The diaphragm-jelly method has a limited application in the public health program.

At the time the foam powder and sponge method was adopted the argument in favor of it was low cost, as sufficient materials for the average patient's use could be purchased at a cost of \$1.20 for a year's supply; and a majority of the patients will use this method faithfully over a long period of time. Jelly-alone was later added in order to get away from certain apparent objections inherent in the sponge and powder; and this method was equally successful, especially in those cases in which there was irritation or in which the husband objected to the sponge.

The technique of the sponge and powder method is simple and easily taught: a flat rubber "airfoam" sponge with a short piece of string attached is moistened and a measured quantity of powder (as recommended by the manufacturer, usually a half teaspoonful) is sprinkled on the sponge and worked up into a foam with the fingers. Then the sponge is easily inserted into the vagina within an hour before intercourse, and if it is removed within eight hours a plain water douche, half before and half after its removal, was recommended. The string attached to the sponge facilitates its removal. A fresh application of sponge and powder before each coitus was advised. The care of the sponge consists of washing it free of foam and allowing it to dry before returning it to the container. Marine sponges of various types and sizes and rubber sponges of different degrees of porosity were tried and the 2½ inch "airfoam" was the most satisfactory.

The jelly or cream method is equally simple. The apparatus consists of a syringe and a tube of material. The syringe is filled from the tube and inserted as far into the vagina as is comfortable and the material is expressed. This injection seems to remain potent as a spermicidal agent for about four hours. A fresh injection is made before each intercourse. Generally a douche is recommended by the manufacturer for comfort, but practically, few of the patients find it necessary.

It is not the function of the State Board of Health, or any of its units, to promote the use of material made by any one manufacturer. County health units are advised from time to time of products which

have been tested by laboratories, and of the clinical results. Each county health officer is at liberty to use such material as he sees fit; but, should they desire to use any product not on the approved list, they are requested to ask the central office in Columbia for information on the product.

No method used will be successful if the patient does not cooperate. Any patient going to a private practitioner will usually cooperate but the public health patient is often only mildly interested, frequently because of mental limitations. This is true of all programs under the public health. In the pregnancy spacing program it is generally advisable, when possible, to secure the cooperation of the husband as this reduces complaints. It is within the

discretion of the director to put the patient on the service if the husband's cooperation cannot be obtained. It generally requires three interviews to secure the patient's cooperation and understanding of methods, and it is rarely worth while to give the patient material at the first visit. In check-up visits the patient is not asked if she used the material in such a way but is told to describe or to demonstrate the use of the material, and to tell how often it has been used. The validity of her statements can often be quickly evaluated by estimating the amount of material that has been used. The patient should report a skipped period promptly but must not discontinue the contraceptive until pregnancy has been diagnosed by a physician.

(To be concluded)

DEATHS

Albert Earle Boozer

Dr. A. E. Boozer, 76, one of Columbia's oldest physicians and former secretary of the State Board of Medical Examiners, died recently after a long illness.

A native of Lexington, S. C., he received his academic degree from the University of S. C. and his medical degree from the University of Pennsylvania (Class 1892). Following his graduation from medical school he located in Columbia where he practiced until his retirement a year ago.

Dr. Boozer served his state and his profession long and well as Secretary to the State Board of Medical Examiners—a position which he held from 1911 to 1943. He served for three years as Superintendent of the Columbia Hospital during the early days of its history. In addition to his other professional work, he served as medical director and examiner for the Carolina Life and Insurance Company for 20 years, as medical referee for the Missouri Life Insurance Company, and assistant medical referee of the Mutual Life Insurance Company.

He is survived by his daughter, Mrs. William Kinsler Beckham, and two granddaughters.

James L. Donnan

Dr. James L. Donnan, 77, retired, Honorary Member of the S. C. Medical Association, died at his home in Ware Shoals on February 1.

Dr. Donnan was a graduate of the University of Georgia School of Medicine (1891).

Robert L. McCrady

Following an intensive search for twenty-four hours the body of Dr. Robert L. McCrady was found in the water near his summer cottage on James Island on April 3. There was no evidence of any violence and the conclusion of the coroner and of the pathologist was "accidental drowning."

A Graduate of the Medical College of the State of S. C. in 1912, Dr. McCrady was elected to the faculty in 1921, serving as assistant in gynecology. Fifty-six years old at the time of his death, Dr. McCrady was professor of gynecology and obstetrics, having served in that capacity for a number of years. He was a member of the board of commissioners of Roper Hospital and also served on the library committee for the Medical College and on the advisory committee to the dean. About two years ago he gave up obstetrics and limited his work to gynecology.

After graduating from the Medical College, Dr. McCrady served his internship at the Montreal General Hospital and while there received special training in gynecology and obstetrics. Upon his return he immediately became connected with the Medical College faculty and advanced to head of the department. He was a member of the surgical staff of Roper Hospital and of the Medical Society of South Carolina.

Dr. McCrady was the son of Louis DeB. McCrady and Mrs. Jane Shackleford McCrady.

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price

Florence, S. C.

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C. FRED WILLIAMS

Dr. C. Fred Williams has resigned as Superintendent of the State Hospital in Columbia and Dr. Coyt Ham has been elected to succeed him. Dr. Williams will continue to hold a connection with the institution through the Department of Research.

Dr. Williams has performed a magnificent service to South Carolina in his years of work, and the manner in which he has conducted himself has not only reflected great credit to himself but also to the medical profession. "Dr. Fred" is a colleague of whom every member of our Association can be proud. We commend him for the task accomplished, we love him for the Christian gentleman which he is, and we wish for him joy and health in the days ahead.

COYT HAM

Dr. Coyt Ham has been elected Superintendent of the State Hospital to succeed Dr. C. Fred Williams. Well qualified by his experience and well liked by his colleagues and the public, we believe that a better choice could not have been made. We congratulate Dr. Ham upon the honor bestowed upon him and assure him our support.

PENICILLIN

Now that penicillin is on the open market, physicians will have opportunity to use this drug more widely than heretofore, and all of us will be watching with interest the results which will be obtained. It is our prediction that the drug will be used in many conditions where it is not indicated and that the unsatisfactory result so obtained will cause some physicians to decry its value. But such has ever been the case when a new drug is available for general use. The pendulum will turn and before long penicillin will assume its rightful place, along with the sulfonamides, as one of the most powerful weapons in our armamentarium—but not as a "wonder drug" which will cure any ailment known to man.

PREPAREDNESS FOR PEACE COMMISSION

Created by an act of the Legislature and appointed by the Governor, the Preparedness for Peace Commission began its work in 1943. An official report was published recently and presented to the General Assembly.

On March 14, 1945, a luncheon was held in Columbia to which representatives of various groups were invited. Representing the South Carolina Medical Association were the President, Dr. W. R. Wallace, and the Secretary-Editor. At this luncheon the report was presented to the group.

The Report is divided into three parts; (1) Reorganization of the State Government, (2) Local Tax System, (3) A Peace-time Economy for South Carolina. Those who are interested should obtain a full copy of the report from the Executive Secretary of the Commission (107 Wade Hampton Office Building, Columbia, S. C.)

It is our purpose to merely outline those sections of the report which directly affect medical affairs in the state.

In Part One, under Reorganization of the State Government, we find the following recommendation;

"Part H. Health

"Recommends the abolition of the present Board of Health which is an executive committee from the State Medical Association together with the Attorney General, the Comptroller General, one representative from the State Pharmaceutical Association, and one from the State Dental Association, and establish a 5-member board appointed by the Governor for overlapping terms of 5 years each.

"The Board would appoint the State Health Officer.

"The work of the Department is commended and expansion is urged."

This recommendation is in line with the rest of the report in Part One in which an effort is made to decrease the number of bureaus and commissions and to create Boards of five members instead of those composed of large numbers, and to do away with ex-officio members on these governing bodies.

It should be noted that this recommendation would not only do away with the present setup in the State Board of Health but makes no provision for any medical representation in the proposed five man Board. It should be borne in mind that this is merely a recommendation and that nothing can be done until necessary legislation is introduced and passed by the Legislature. So far we have not heard of any such legislation being introduced in the law making body.

In Past Three, we find a section headed Health, which reads as follows;

"6. Health.

"a. There is a definite need for a state-wide survey of health conditions, including our needs in the field of medical and hospital care, preventive medicine, and sanitation.

"b. There is need for study of our entire program of hospitalization, including the treatment of the mentally ill. Any survey of health needs should take cognizance of the needs of our State Institutions, in their effort to meet health requirements of our State in their respective fields.

"c. Hospitals built in the post-war period should be established by area needs, rather than by individual communities. Good roads make area hospital centers advisable and such centers offer greater advantages than local facilities. A number of areas in the State have no hospitals, or too few hospital beds. Area hospitals should include sufficient hospital space and clinical facilities to take care of all area needs."

The recommendations are directly in line with certain points in our own Ten Point Program. It places our Association in a strategic position in that we will be able to assist materially, if not to lead, in the making of surveys and in instituting programs in the field of hospital building and medical welfare. The necessity for continuing and expanding our work in the Ten Point Program is evident.

As we listened to the discussion of the entire Report of the Commission, we were impressed with the amount of work which had been done in its preparation and with the forward looking and progressive recommendations made. In certain details (as in the recommendation relative to the State Board of Health) we disagreed with proposed changes, but in the main we believe that the Commission has rendered a real service to the state. It is our hope that this Report will be used as a guide for future developments in South Carolina.

IN SPITE OF DIFFICULTIES

When the fact was borne in upon us that we would not be able to hold our annual session, a cry of despair rose within us. "How will we be able to publish the Journal, without the papers which we receive regularly from the annual scientific session?" was the question which we asked ourselves.

And in our imagination, we would hear every other medical editor in the county asking himself the same question.

To secure good articles for publication even in times of peace, is no easy task. Many physicians are capable of preparing such articles, but the actual writing requires both time and effort. The incentive of a public presentation, the availability of spare time, the desire to give others the benefit of one's own study and experience—these are the main factors which lead physicians to prepare material for publication. But today, alas, the opportunity for public presentation and the availability of spare time are largely nonexistent, and the desire to share one's thoughts and experiences with others is largely buried under the desire to secure a few moments of recreation and rest after a hard days work. As a result we anticipate a dearth of scientific papers from our own members during the coming year. We sincerely hope our predictions will not prove to be true.

On the other hand, we are convinced that there is a greater need for the publication of our Journal now than at any time in recent years. It is the one medium through which each member of the Association can keep in touch with his colleagues throughout the state and with the work of the Association itself. It should be a clearing house for information—national, state, and local—which pertains to medical affairs. It should bring to the attention of our readers the programs and projects of our own organization. It should keep physicians throughout the state acquainted with the progress of our own Ten Point Program. It should bring to our colleagues, those in service and those at home, news concerning each other. It should serve as a Forum where our members can express their thoughts and views on varied subjects. And, it should afford each of the busy physicians who reads its pages an opportunity, monthly, to read scientific discussions which are of value to them in their every day practice.

Yes, we are firmly convinced that the publication of our Journal must be continued and that its usefulness must be increased—regardless of how difficult the task may be. And we believe that this can be done.

It means the burning of more midnight oil on the part of the Editorial Board and of the Editor. It means that those physicians in the state who have a gift for writing—even though that gift has been dormant for some time—must put in the extra hours necessary for the writing of articles. It means that we will, without any apologies, reprint articles—in part or in full—which have appeared in other state journals. (When a physician in Washington or Nebraska or Louisiana or Connecticut writes a good article which is published in his state medical journal, why shouldn't the physician in South Carolina receive the benefit of his work and thought. We

believe he should and we propose to reprint such papers,—giving full credit to the writer and to the journal of publication.) It means greater help from members, county society secretaries in particular, in sending in news items and other types of informa-

tion for publication. In brief, with the uncertainties which face us and with the difficulties which have arisen to beset us, it would be foolish to make promises except for this—we will do the best we can.

The Ten Point Program

M. L. MEADORS, EXECUTIVE DIRECTOR AND COUNSEL

THE PEPPER COMMITTEE AND THE DOCTORS

Reference has been made heretofore in this column to the work of the Pepper Committee in Congress. This subcommittee of the Senate Committee on Labor and Education, headed by Senator Pepper of Florida, and charged with the duty of studying wartime health, has held a number of hearings during the past year and has called before it as witnesses some of the outstanding experts on medical education, medical care and hospital service throughout the nation. Some of these have been officials of the Public Health Service, high-ranking officers of the Army and Navy, people in important positions in the work of Public Welfare. They have also included outstanding members of the American Medical Association and the American Hospital Association, educators of national importance. All in all, the Committee apparently has endeavored to obtain a fair cross-section of opinion and expert advice on the subject under investigation. Reports of the testimony have been released from time to time and they make interesting reading.

There is scarcely any doubt of the fact that from the work of this Committee there will be evolved some far-reaching and comprehensive legislation, to be introduced as a Committee bill, for the purpose of bringing about such reforms in medical practice as the Committee may think are indicated by the mass of testimony which they have heard.

The Committee's work has not been finished and an interim report released in January states frankly the necessity of further study to determine just what course the efforts and improvements should take. This report emphasizes the fact, which was developed in the testimony, that 4½ million young men in their prime were found unfit for military service on account of physical and mental difficulties. On the basis of these and other figures, it was estimated that at least 40% of the 22 million men of military age are unfit for general military duty.

Other figures equally startling were reported in connection with other groups of the population. In a survey made by the Farm Security Administration, covering 11,495 individuals in 2,480 farm families residing in 21 typical rural counties, in 1940, 96% of those examined had significant physical defects. Of 150,000 young people examined by physi-

cians for the National Youth Administration in 1941, only 10 out of each 100 had no defects for which the examiner made a recommendation. The high defect rates were not limited to the low income groups although, naturally, the percentage was greater there. According to a study by the Life Extension Institute, in examinations of 300,000 policy holders selected without regard to sex, age or occupation, it was found that 59% were so physically impaired as to need the services of a physician.

The Pepper Subcommittee does not attempt to charge the medical profession with *full* responsibility for this situation but, of course, there have been in the past few months and there will be in the months immediately ahead some who will use these statistics in the effort to support their argument that the medical profession has failed in the discharge of its duties to the public. It will make interesting speech material in the halls of Congress, and will not be without considerable force in the minds of many who may now be seeking only some justification to support a bill to place the practice of medicine firmly within the control and direction of the Government. So, it is obvious that the matter is very much alive and some definite development may be expected within a comparatively short time.

Another matter discussed in the report is the plan of Dr. Parran, Surgeon-General of the Public Health Service, for a system of hospitals and health centers reaching into every community and by means of which it is said even the rural areas would have the benefit of sufficient medical facilities close at hand. Still another subject with which the report deals is that of the distribution of physicians. It points out, for instance, that the number in Massachusetts in proportion to population, is three times that of the number of active physicians in South Carolina. Obviously, this situation is worse in the rural communities than elsewhere but no reasonable person can blame the doctor for not wishing to locate in a community where he is offered nothing in the way of professional or financial advancement.

After all, the duty of the Committee should be to determine how to relieve any unfavorable situation which may exist rather than simply to try to place the blame for its existence. And, in the final analysis, it will make little difference whether the doctors are to blame for the fact that many people do not

receive adequate medical care. A plan will be adopted which will be expected to assure adequate care and the effect which that plan may have upon the private practice of medicine will be, so far as Congress and the public are concerned, beside the point.

After reviewing the testimony along the lines indicated, the Committee, in the report, has this to say:

"Evidence such as this leads the Subcommittee to conclude that the "pay-as-you-go" or fee-for-service system, which is now the predominant method of payment for medical services, is not well suited to the needs of most people or to the widest possible distribution of high-quality medical care. It tends to keep people away from the doctor until illness has reached a stage where treatment is likely to be prolonged and medical bills large. It deters patients from seeking services which are sometimes essential, such as specialist care, laboratory and X-ray examinations, and hospitalization. Individuals with low incomes, whose need is greatest, are most likely to postpone or forego diagnosis and treatment."

In the course of our observation and study of the subject since the beginning of our work with the State Association, it has become clear that there are within the profession itself three distinct attitudes or points of view. First, there are those who hold the view that state controlled medicine can be prevented and that a vigorous fight must be waged against it in any form—no quarter asked and none given. Second, there is the view held by some of the other extreme, that state controlled medicine is inevitable and that it is a waste of time and money on the part of the profession to attempt to take any measures with regard to it and third, there is the view that, whatever the outcome, the problem can best be met through positive active effort by the profession to direct the development of whatever changes are to be made; to make concessions where necessary and to cooperate in working out a plan for the good of the public as a whole and one which is satisfactory to the profession.

Our own view coincides with the last of these three and this is based upon preliminary conclusions drawn somewhat from each of the two other views. That is, it appears now to be rather obvious that social medicine, in some form, is bound to come but that it need not necessarily be state controlled. Whether or not it shall be depends on the ability of the profession to face the situation squarely—to put itself in an attitude of negotiation and adopt a spirit of willingness to cooperate in working out the right solution. In a recent issue of the Public Health reports, Mr. Berge, an Assistant Attorney General of the United States, is quoted as having stated in an address to one of the scientific societies that "a new medical order is inevitable. Whether we shall cling to the old order or create a new one is not the question. The swift course of events has decreed that there can be no turning back. The question is rather what sort of a medical order it is

going to be and whether it is the best which wisdom and knowledge can contrive - - -. Is it to be shaped by the best understanding which law, medicine and the social studies can bring to it or is it to be constructed by amateurs in ignorance but with good intentions?" Of course, Mr. Berge, who is merely another lawyer despite his title as Assistant Attorney General, may be no authority on the subject, but we think he has aptly phrased a correct statement of the situation as it now exists.

On February 23rd, we attended a conference in Atlanta of the officers of the State Associations of six southern states, arranged and called by Dr. Paullin, Past President of the American Medical Association, and at which were present Dr. Victor Johnson, who made the address at the banquet in connection with the Refresher Course at the Medical College last November, and others prominent in organized medicine. Senator Pepper was in the city and Dr. Paullin arranged with him to meet with and talk to the group during the afternoon session. Remaining seated, the Senator spoke informally, for approximately one hour, of the work of his Committee and of the plans for future legislation. He began by assuring the group that he does not advocate socialized medicine and that he has no quarrel with those who object to the compulsory features of the Wagner-Murray-Dingell Bill. On the other hand, he left no doubt of his determination and that of his Committee (which has now been organized as a permanent subcommittee) to work out some solution of the problem which will result in the furnishing of adequate medical care to the entire population. Stating that no hard and fast conclusion has been reached and that he was "just thinking out loud," he described the plan which he has in mind as one of voluntary non-profit medical care insurance, organized on the basis of state units with general supervision by the Federal Government. Payments by individuals would be graduated according to their ability to pay and this could be determined on the basis of the income tax records. For example, a person with a taxable income of \$500 might pay 50c per month for each member of his family; one with a taxable income of from \$500 to \$1000 might pay \$1.00 per month; those with incomes of from \$1000 to \$2000, \$2.00 per month and so on until those paying taxes on incomes in excess of \$5000 or some similar figure would pay perhaps \$10.00 per month for each member of his family. In return for this, the taxpayer and his family would receive full medical care and hospital treatment when needed. The Senator emphasized that the plan was to be voluntary and obviously many of those with high incomes would not wish to join. The payments by the smaller income groups would not be sufficient to finance the arrangement and he proposes that it should be subsidized by federal grants matched by state appropriations. There would be organized in each state, according to a general uniform plan, a council to be set up under legis-

lative authority and on which various groups would be represented. He referred to a conversation with someone recently in which he was asked whether he would be willing to leave the administration of any medical plan entirely in the hands of the doctors. To this, the Senator said, he replied emphatically "No"—not any more than he would leave the administration of legal plans entirely in the hands of the lawyers of whom he is one. On the other hand, he readily agrees that the medical profession should be well represented in the proposed state councils and these should include also representatives of the hospitals, the Boards of Health, nursing, agriculture, industry and labor.

Although Senator Pepper stated that he was merely thinking out loud and that nothing is "cut and dried," it was impossible to escape the conclusion that he was outlining a definite plan now in the making. In all probability, it will be introduced in the Senate in the near future and perhaps in connection with the promised social security message of the President.

Such a plan, while of course not as satisfactory as the profession's present freedom of practice, would surely be far less objectionable than one which required compulsory insurance and did not provide for administration within the individual states. We have argued strenuously within the past year or two that one of the chief objections to the Wagner Murray-Dingell Bill was that it placed control squarely in the hands of the Surgeon-General, and that administration of any plan should be left to the states. It appears that the efforts along this line have not been entirely in vain. Evidently, the freedom of choice of physicians by the patient would be safeguarded so far as possible under such an arrangement, although regulation of the amounts of fees for various services would appear to be inevitable.

The Senator spoke freely and, apparently, frankly. He made it clear that he was speaking for the record and he gave the impression, to the writer, at least, that he was ready to meet the profession on a basis of equality; to reason with it and to enlist its cooperation in working out the ultimate plan. The fact that he spoke at length and invited questions and discussion at the conclusion of his remarks was further indication of a reasonable attitude on his part. All this, one may readily suppose, is the result, in part at least, of the statements of many of the expert witnesses who testified before his Committee.

There was close similarity between the general outline of the administrative plan discussed by Senator Pepper with that proposed under the Hill-Burton Bill, now before the Senate, providing for a survey of hospital facilities, to be followed by a program of hospital construction throughout the nation. The same sort of State Councils, as provided for in the Hill-Burton Bill, are contemplated under Senator Pepper's plan. He made reference also to the existing social security organization. On the

whole, there is little doubt, apparently, that nationwide medical insurance along this general line is on the way.

If this is true, the question now is what shall be the attitude of the medical profession? We are fortunate in having received an indication in advance of the course which the matter probably will take. Advantage should be taken of the opportunity to consider the matter and decide whether we shall make a determined effort to so guide and shape the formulation of the ultimate statute that it will be satisfactory to profession and public alike or whether the doctors shall go all out in a full dress fight to prevent its adoption in any form.

The inclusion of medical care within the scope of the term "social security" appears inevitable. The position which the doctors shall occupy in the new plan for social security can be determined, to some extent, at least by the thought, efforts and constructive suggestions and cooperation of the profession itself at this time.

(Senator Pepper's remarks are reported in full in the March 10th issue of the American Medical Association Journal, pages 600 and 601).

"BLUE CROSS" BILL PASSES SENATE

Developments in connection with the "Blue Cross" Bill since publication of the last issue of the Journal have been more encouraging. The second hearing before the Senate Committee on Banking and Insurance was held on February 21 as scheduled. Senator Berry of Richland proposed a number of amendments, all of which were fully discussed. We were able to reach agreement with the Senator on certain of the amendments which would not affect the Bill unfavorably and some of the others he agreed to withdraw. Mr. August Kohn of Columbia appeared in opposition on behalf of parties not named. The Bill was then reported out favorably by the Committee with recommendation of the amendments as agreed to and came before the Senate for second reading on February 28. On motion of Senator Eatmon of Williamsburg, debate was postponed until Wednesday of the following week, March 7. On the latter date, it was taken up on the floor of the Senate and, after considerable discussion, the elimination of some of the amendments which had been proposed by Senator Berry and the alteration of others, the Bill was passed on second reading and, on Tuesday of the following week, March 13, was given third reading and sent to the House. The interest and activity of Senator Warren of Hampton and Senator Harvey of Beaufort were of much value in the final stages of the passage of the Bill in the Senate.

In the House of Representatives, the Bill was read the first time on Wednesday, March 14, and referred to the Committee on Medical Affairs. That Committee, having already investigated the Bill, reported it out favorably on the same day, whereupon it was referred to the Committee on Banking and

Insurance, of which Mr. Marion F. Winter of Berkeley County is Chairman. At the present writing it appears that much the same procedure as was experienced in the Senate will have to be duplicated in the House of Representatives but we believe the Bill will be passed eventually. When the matter came before the Senate for the vote on both the second and third readings, there were no opposing votes registered against it. We believe virtually the same thing will be true in the House provided it is brought to that point. Unless the Bill is kept in the Committee too long and if the Legislature does not adjourn before it is reported out for debate and consideration on the floor, the Bill should pass and become law within the near future.

We are keeping constantly in touch with this and are very hopeful that we may be able to report the passage and ratification of the Act in this column next month.

JOINT NATIONAL ACTION PROPOSED BY COUNCIL ON MEDICAL SERVICE PLAN

The March issue of the BLUE CROSS BULLETIN, publication of the Hospital Service Plan Commission of the AHA, reports the meeting on February 10 in Chicago of the members of the Medical Service Plans' Council of America to effect a formal organization for joint action by all voluntary, non-profit medical service prepayment plan organized by local, county and state Medical Societies, with the purpose "to develop this voluntary movement in such manner as to protect the public welfare and wholly safeguard the high quality of medical care achieved by the profession in the United States and Canada." The proposed organization would follow generally the pattern of the Hospital Service Plan Commission in coordinating the activities and standardizing the benefits and methods of operation of the various plans.

Perhaps the most significant feature of the meeting was the list of those who attended and of the speakers. Among the latter were Dr. John H. Fitzgibbon, Chairman of the Council on Medical Service and Public Relations, and Dr. Morris Fishbein, Editor of the Journal of the American Medical Association.

Dr. Fitzgibbon spoke during the morning session describing the purposes and activities of the Council. Dr. Fishbein addressed the group during luncheon. According to the Blue Cross Bulletin, he encouraged those present to do their best to aid medical service plans to grow, to coordinate activities and to attain financial soundness.

He is also reported to have said that he was convinced that federal health legislation would not include compulsory health insurance. This coincides with the impression created by the remarks of Senator Pepper at the Atlanta Conference, referred to elsewhere in this column.

MEETING OF THE SOUTH CAROLINA MEDICAL SOCIETY

On February 27, we were invited to appear with Dr. Tom Brockman on the program of the South Carolina Medical Society in Charleston. The invitation and reception accorded one not a member of the medical profession was wholly in accord with the gracious hospitality for which Charleston is noted.

Dr. Brockman discussed convincingly the dangers of: "Political Medicine." Our subject, "The Doctor and Social Security," embraced to a large extent the ideas expressed elsewhere on this page.

Following the meeting, there was a delightful reception at the home of Dr. Clay Evatt, on the Battery. The evening was most pleasant and thoroughly in keeping with the Charleston atmosphere.

NEWS ITEMS

Jacob Zalin

Capt. Jacob Zalin, a prisoner of the Japanese, was rescued recently by our forces and is now safe.

Capt. Zalin, a graduate of the Medical College of the State of S. C. (Class 1936) entered the service in 1940. He was on Corregidor and was captured by the Japanese when the Philippines fell. His family had received three cards from him from that time up until he was rescued.

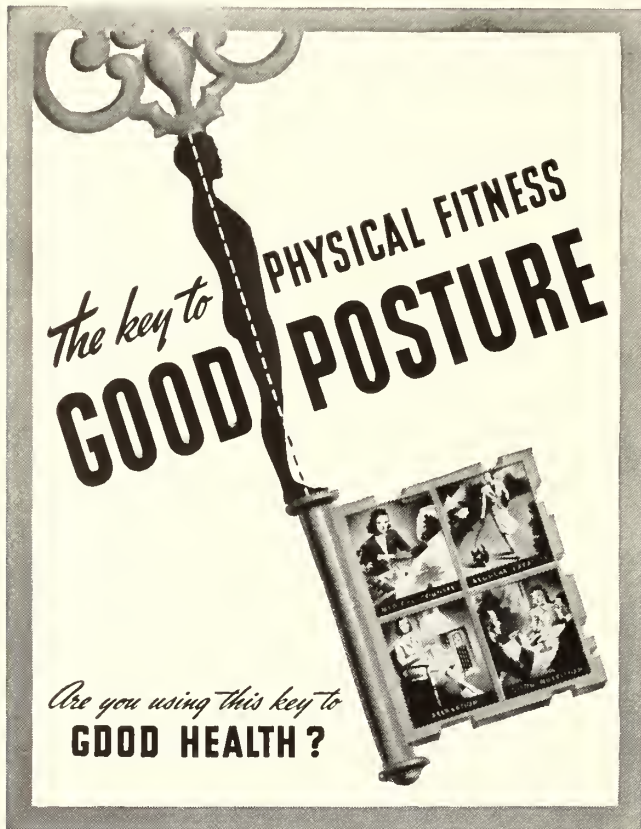
Colonel Hugh Smith (Greenville) is now stationed

at the Army Hospital, at Anniston, Alabama.

Major Frank P. Coleman, formerly of Columbia, is now stationed at McGuire General Hospital, Richmond.

The eleventh annual meeting of the American College of Chest Physicians, scheduled to be held at Philadelphia, June 16-19, 1945, has been cancelled. The Board of Regents of the College will meet at Chicago in June to transact the business of the College.

May 7th-12th **CAMP** 7th Annual



TWO OF A SERIES of educational posters in full color telling the story of Good Posture as one of the elements in Good Health and Physical Fitness. The Poster on the left broadens the theme to stress the importance of medical counsel, sound nutrition, relaxation and sensible exercise.

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IN ITS SEVENTH YEAR, National Posture Week continues its sound and ethical program of focusing the attention of the country on the significance of Good Posture to good health and physical fitness. As the years go on, it is becoming evident that the special events of National Posture Week and the year-round program have encouraged many suffering from poor body mechanics to seek professional counsel.

While the public will be reached through every popular channel of public information, emphasis is again being placed on the distribution of authoritative literature to schools, colleges, medical and gov-

ernment bodies, industrial, professional and civic public health groups.

Physicians, educators and lay groups in the field of public health have shown in practical cooperation and voluminous correspondence that they approve the content and methods of National Posture Week and its year-round physical fitness program. It is our hope that we will continue to merit this support in this year of Victory and during the post-war years of adjustment which will present so many problems to those charged with maintaining the health of the nation.

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PUBLIC HEALTH NEWS

DR. HAYNE'S 73RD BIRTHDAY SUNDAY, MARCH 18

34 Years With State Board of Health

Dr. James A. Hayne, Director of the Division of Public Health Education, will celebrate his 73rd birthday Sunday, March 18. Two weeks later he will have completed 34 years of service with the State Board of Health, for it was on April 1, 1911, that he was appointed State Health Officer. Dr. Hayne resigned as State Health Officer May 1, 1944, to become State Director of Public Health Education. On July 1 he assumed his present position as Director of the Division of Health Education.

Receiving his degree in medicine from the Medical College of South Carolina in 1895, Dr. Hayne began his career as a practicing physician in Greenville, later practicing in Athens, Georgia, Calhoun Falls and Blackstock. In 1911 he was appointed State Health Officer and served continuously in that capacity for 33 years. During that time Dr. Hayne gained international recognition as an outstanding authority in the field of preventive medicine. Many years ago the Medical College of the State of South Carolina conferred upon him the degree of Doctor of Public Health.

Dr. Hayne's 73rd birthday will find him still young and handsome and, as he says, still able to "see, hear, taste, smell and touch, and enjoy all five senses."

LITTLE JACK DENTAL HEALTH PUPPET SHOW GROWING MORE POPULAR WITH SCHOOLS AND COUNTY HEALTH DEPARTMENTS

The Division of Dental Health's educational puppet show, Little Jack, is growing more and more popular with both schools and County Health Departments, according to all reports.

This week the show is playing in Colleton County. Last week it appeared in a number of schools in Dorchester County. In both counties a hearty welcome and full cooperation were extended the puppeteers, Miss Rebecca Wiley and Miss Nancy Shirley, by the personnel of the County Health Departments, and the show in every school was a huge success.

Dr. George A. Bunch, Director of the Division of Dental Health, has expressed keen satisfaction in the growing interest of County Health Departments in the Little Jack show. "It is a part of the health department's own educational program in the schools," he says, "and its success depends upon the interest shown in it by the personnel of the health department. Particularly gratifying is the fact that all health departments now arrange for one or more members of their personnel to accompany the pup-

peteers to the schools and introduce them to the teachers and children."

It is encouraging to note that the County Health Departments are becoming increasingly appreciative of the value of the show not only as a health education medium, but also as an important means of bringing them and the schools closer together.

SOUTHEASTERN CONFERENCE FOR ERADI- CATION OF VICE HELD IN COLUMBIA MARCH 8

300 Delegates Attend Meeting

Every County In South Carolina Represented

More than 300 delegates from seven Southeastern states and from every county in South Carolina attended the Social Protection Conference called by Governor Ransome J. Williams and held Thursday, March 8 in Columbia.

Edgar A. Brown, President of the State Senate, presided at the morning session. During the afternoon session H. S. Reeves, State Representative of the Social Protection Division, and Dr. Ben F. Wyman, State Health Officer, presided. Speakers were Fred D. Marshall of Columbia, Mayor; Brig. Gen. D. C. Richart, Post Commander of Fort Jackson; Governor Williams; Lieut. Col. Thomas H. Sternberg, MC, USA, Washington, D. C.; Dr. J. R. Heller, Jr.; Chief of VD Division, USPHS; Commander W. H. Schwartz, MC, USN, Washington, D. C.; Thomas Devine, Director of the Social Protection Division, Federal Security Agency, Washington, D. C.; Dr. Walter Clarke, Executive Director, American Social Hygiene Association.

Doctor Clarke, speaking on community participation, emphasized the importance of community leaders being well informed about these matters and in continuing to support public officials in the program.

"This war-stimulated, intensive campaign must be maintained until victory is won," he added. "That obviously is our first obligation. But it would be short-sighted not to give serious thought, even in the midst of the present campaign, to problems of the future which we must prepare to meet now.

"It surely is not too soon to consider in at least a preliminary way the problem related to venereal diseases, prostitution and promiscuity, with which the United States will be confronted after the war.

"I would like to give some consideration to one of the most important, and in a sense most neglected, aspects of the campaign against the venereal diseases. And basic in this consideration is the fact that, in the last analysis, it is promiscuity that spreads venereal disease."

As a method of meeting these problems he advocated not only vigorous continuous repression of prostitution, but development and strengthening of welfare and educational services throughout every

community. He emphasized the importance of an extension of opportunities for wholesome leisure time and recreational activities.

Mrs. Florine Ellis, Social Protection Representative, Region 7, former Executive Secretary of the Family Welfare Society, Greenville, spoke on welfare in community action. She said there is a missing link and, in her observation, that missing link is a failure on the part of communities to make full use of redirection facilities available through social agencies. All over the country schools are making plans to teach what they call "Health and Human Relations" with a need for sex education as a basis for the curriculum. The incoming generation will undoubtedly be better informed concerning sex matters than the present generation.

"We need to emphasize the fact," Mrs. Ellis said, "that the biggest job in the world is that of rearing children. Entirely too much praise has been given to those who work out of the home and not enough attention paid to those who stay at home and take care of the children." She quoted Dr. Miriam Van

Waters, superintendent of Massachusetts women's prison, as saying that she believed strongly that "broken homes are our largest contributing factor to delinquency."

"This opinion," she added, "is certainly borne out in the study made recently of the first 100 women and girls referred to social agencies by the recorder's court of Greenville. Of 100 studied, 78 were from broken homes or experiencing family conflicts of one kind or another. Emotional factors were present as secondary causes in most of the remaining individuals."

Other speakers on the program were C. O. Getty, Chairman of the Education Section, Charleston Social Protection Committee and General Secretary of the YMCA, Charleston; Dr. Ben F. Wyman, State Health Officer; Dr. Joe M. Chisolm, Director of the State Board of Health's VD Control Division; Mr. Ford S. Williams (Major), Senior Medical Officer, Public Health Hospital; Earle G. Lippincott of Atlanta, Regional Social Protection Representative.

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CORRESPONDENCE

23 February 1945

I am in receipt of your thoughtful letter of November 22, 1944. It appears that you and the South Carolina Medical Association have considered carefully, many aspects of current affairs and post-war planning. There are far more questions prepared that I am in position to make a reasonable answer to. However, as for my opinions on the labor situation and race questions, I am relatively sure the United States mail would be unwilling to transmit my opinions on these subjects.

Relative to post-war desires of doctors on duty with the Armed Forces: Those of us who are doing administrative rather than professional work would like at least a year of practical professional training in our field. I believe the U. S. Government has some vague plans for supporting some such program. Some time back a questionnaire was sent to me to fill out for the post-war planning branch of the A. M. A. Those of us in Germany are too far removed to know whether this will be translated into practical application, filed in the nearest wastepaper basket, or used to make up the paper shortage.

I am not receiving the Journal, (South Carolina) and would like very much to receive it at the above address.

Am very happy to learn that you and the South Carolina Medical Association are thinking along practical and constructive lines. You may be assured that it is a great source of comfort to those of us in the Service.

Yours truly,
Thomas L. Lucas,
Lt. Col., M. C.,
Division Surgeon

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From where I sit
by Joe Marsh

Dr. Walters Solves the Locust Problem

Maybe it's because he's a doctor, but Dr. Walters is pretty smart at solving other people's problems. Like Alvin Blake's locusts.

For years, Alvin has been trying to get rid of a grove of locusts. They aren't using up any good land, but they annoy Alvin. Every time he cuts them down, up they shoot again.

"What'll I do about them locusts?" Alvin asks Dr. Walters. "Well, if you can't get rid of 'em," says the doctor, "I'd say you better get to like 'em."

From where I sit, that's sound philosophy—applies to people just as much as locust trees. You can't always change folks to your way of thinking—some may prefer beer to buttermilk, or a double harness to a single one—but you can get to like them (if you take the trouble).

And first thing you know, the little differences don't matter.

Joe Marsh

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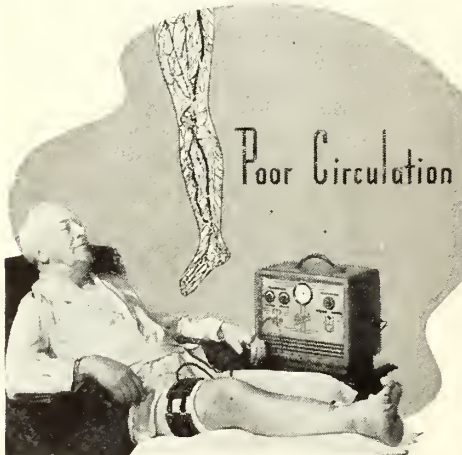
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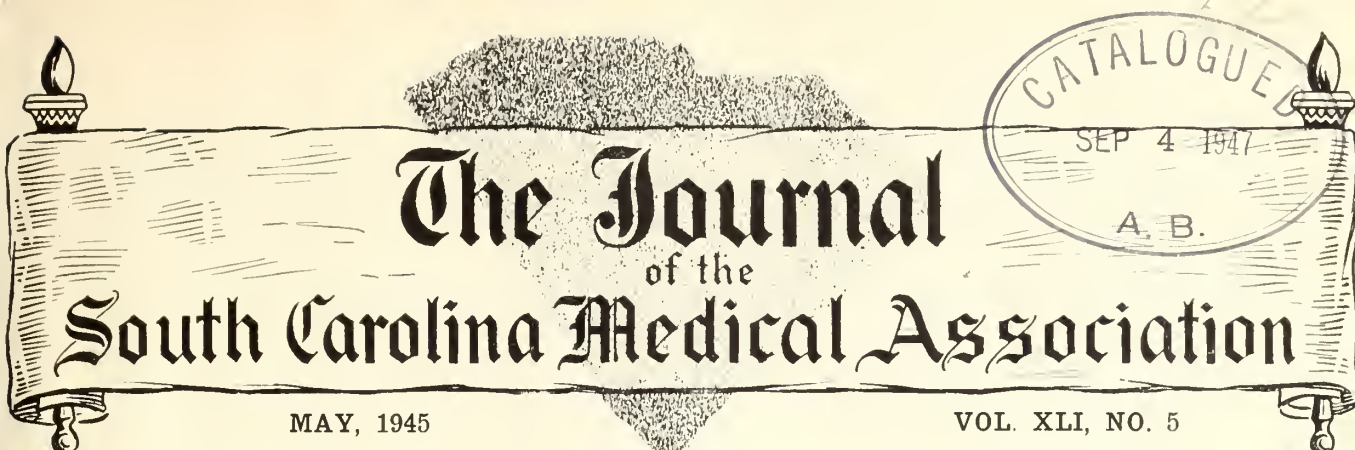
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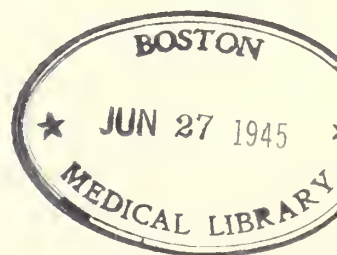
MAY, 1945

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Annual Meeting
Council

South Carolina Medical Association
April 17, 1945



BACKGROUND

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1. Bull. N. Y. Acad. Med. 13:427 (Aug.) 1942.

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Entered as second-class matter February 9, 1916, at the post office at Greenville, South Carolina, under Act of Mar. 3, 1879. Accepted for mailing at special rate of postage provided for in Sec. 1103 Act of October 3, 1917, authorized Aug. 2, 1918.

THE JOURNAL

of the

South Carolina Medical Association

VOLUME XLI

May, 1945

NUMBER 5

Annual Meeting of Council

Columbia, S. C.

April 17, 1945

The annual meeting of the Council of the South Carolina Medical Association was held in Columbia on April 17, 1945 with all members of Council present.

In his opening remarks the Chairman, Dr. Frank Cain, stressed the importance of this particular meeting and the grave responsibility which rested upon Council. Due to wartime restrictions it was found impossible to have a meeting of the House of Delegates at the present time and it was incumbent upon Council, as the Executive Body of the Association between meetings of the House of Delegates, to carry on the work of the Association and to make plans for the future. Every member of the Council appeared to sense the seriousness of the situation and matters presented for discussion were considered carefully.

The reports of the various committees, some of which had already been published in the Journal, were presented and discussed.

The report of the Secretary which is printed in this issue of the Journal, was read and discussed. With certain changes and amendments the recommendations contained in this report were adopted. Provision was made for a continuation of the Ten Point Program with adequate financial support. Council agreed to recommend to the House of Delegates that annual dues for membership be raised from \$10.00 to \$20.00.

The report of Mr. M. L. Meadors, Executive Director and Counsel of the Ten Point Program, was read and accepted as information. Mr. Meadors was commended for his splendid work. Council ordered that his report be published in the Journal (see below).

Dr. W. R. Wallace, Chairman, presented the report of the Executive Committee of the State Board of Health, and Dr. T. R. Littlejohn, Chairman, presented the report of the Memorial Committee. These reports were received as information and the Secretary was instructed to have them published (see below).

After considerable discussion Council felt that the best interests of the Association would be served by installing Dr. W. T. Brockman, President-Elect, as President of the Association at this meeting of Council and this was done.

It was brought to the attention of Council that the terms of two members of the State Board of Medi-

cal Examiners would soon expire and that Dr. J. D. Guess had tendered his resignation as a member of the State Board of Examination and Registration of Nurses. Since the law requires that physicians serving on these Boards shall be nominated to the Governor for appointment and since Council is the only Executive Body of the Association which can meet at the present time, the following nominations were submitted to the Governor: For membership on the State Board of Medical Examiners to represent the First District, Dr. A. R. Johnston of St. George, who would succeed Captain George C. Brown of Walterboro. Capt. Brown had requested that someone else serve in his place. Dr. C. H. Blake of Greenwood was nominated to succeed himself on the State Board of Medical Examiners. Dr. Jack D. Parker of Greenville was nominated to succeed Dr. J. D. Guess, resigned, for membership on the State Board of Examination and Registration of Nurses.

Council prepared for the 1945-46 session by re-electing the following officers: Chairman, Dr. Frank Cain, of Charleston; Vice Chairman, Dr. R. B. Durham, of Columbia; Dr. J. P. Price, of Florence, Editor of the Journal.

REPORT OF THE SECRETARY

Since there is uncertainty as to the possibility of holding a meeting of the House of Delegates this year, your Secretary has deemed it wise to present a full report of the year's activities to the Council. Should there be a meeting of the House of Delegates later this report will be brought up to date and presented at that time.

MEMBERSHIP

Our membership now stands at 942, as compared with 937 last year. Broken down into groups, we find 172 of our members in the service, 98 as honorary members, and 672 as regular paying members.

FINANCES

The certified financial report of the Association has been sent to the Chairman of Council and has been published in the March issue of the Journal.

The finances of the Association are in sound condition. \$3,000 was transferred from the general account to the special account for the Ten Point Program and even with this there was a surplus of \$456.02 for the year.

To finance the Ten Point Program, your Secretary was instructed to raise an additional \$5,000 by volun-

tary contribution from the membership. The response of the members was gratifying and the total amount raised was \$5,464.09.

That we are in good financial condition is due to the fact that our members have paid their dues well and that our advertising revenue from the Journal is at an all time high. As will be noted, the revenue from advertising last year was \$5,172.87 as compared with \$3,794.57, for the previous year. This increase in funds derived from advertising had been due to the accomplishments of the Cooperative Medical Advertising Bureau in Chicago and we wish to commend Mr. H. L. Sandberg, Executive Director of that organization, for his fine work.

As we face the next year's work, it is anticipated that we will have a sufficient amount on hand to carry on our usual activities and to have a surplus of \$3,500.00. This, however, does not make any provision for a continuation of the Ten Point Program after September 1, 1945. Your Secretary believes this surplus of \$3,500.00 would be sufficient to carry on the work of our Executive Director in the Ten Point Program until January 1, 1946. He would suggest, therefore, that Council empower the Treasurer to transfer \$3,500 from the general fund of the Association to the special account of the Ten Point Program and that Council engage Mr. Meadors to continue his work at his present salary.

Further in this report your Secretary will discuss the Ten Point Program. At this point, he would urge that provision be made for making it a permanent part of our Association's activities and that appropriate provision be made for its financial support. The best way to do this would be through an increase in the annual dues of the members and your Secretary would recommend that this matter be carefully considered when the House of Delegates convenes. Should it be impossible to hold such a meeting this year, your Secretary would urge that this Council endorse a voluntary contribution campaign such as we had last year and instruct your Secretary to attempt to raise \$6,000. Your Secretary believes that this \$6,000 with such surplus funds as may be available will finance the Ten Point Program through 1946.

THE JOURNAL

The problem of securing a sufficient amount of good scientific material for our Journal in the absence of an Annual Scientific Session of the Association, is extremely difficult. Your Secretary would call attention to an editorial which appears in this month's (April) issue of the Journal in which this subject is discussed in full and in which suggestions are made whereby the scientific section of the Journal may be maintained at a high level. Your Secretary is convinced that the Journal is of greater importance to the members than ever before and begs the support of every member toward making it a successful publication.

MEMBERS IN SERVICE

Letters have been sent out from the Secretary's office to all of our colleagues in the service telling of the work of the Association. Through these letters an effort has been made to find out some of the problems which our colleagues face, some of their ideas on things in general and things relating to medical practice in particular. Your Secretary has also attempted to find out from these medical officers what they wanted from their colleagues at home as they face, in the not too distant future, discharge from the armed forces and a return to civilian practice. Many of the responses which have been received have been published in the Journal and this practice will be continued. It is hoped that this question of the returning medical officer will receive careful consideration by the Association.

ACTIVITIES OF COUNTY AND DISTRICT SOCIETIES

Our larger county societies and many of our district societies have continued to carry on their usual activities and some of the scientific programs which they have presented have been outstanding. Unfortunately, many of our smaller county societies have curtailed their activities to a great extent and some are not even having meetings at regular intervals. Although this is a state of affairs which is easily understandable, it is also unfortunate since the county medical society will always be the foundation stone upon which our State Association rests. Your Secretary would urge that these smaller county societies continue to function as integral units and that they unite with adjacent county societies or with all of the societies in a district, in more frequent scientific meetings.

SECRETARY'S ACTIVITIES

Your Secretary has attempted to carry on his work as best he could under our present wartime restrictions. He has visited and spoken before several county societies and before seven of the nine district societies. In company with the President-Elect and the Executive Director of the Ten Point Program he attended the Annual Conference of Secretaries and Editors in Chicago. In company with the same two individuals he attended a special meeting of state medical officers in Atlanta, and was privileged to hear a frank discussion on the medical situation and possible medical legislation by Senator Pepper of Florida. He is a member of the proposed directorate of a Medical Service Plan for South Carolina and has appeared before several committees of the Legislature in support of the bill which would allow for the creation of such a service (commonly known as the Blue Cross Hospital Service). With the President, he attended a banquet in Columbia at which the report of the South Carolina Preparedness for Peace Commission was presented for consideration. He has attended all of the meetings of Council. And finally, he has attempted to carry on the daily work of the office with its correspondence and routine activity. Again he wishes to give credit to the efficient and thorough work of the Business Manager of the Association, Mrs. Claude Watson, realizing that without her service much of the work would either have been done very poorly or else not at all.

THE TEN POINT PROGRAM

Since the Executive Director of the Ten Point Program will present a detailed report, your Secretary will only make a few observations on this part of the Association's work.

Although the Ten Point Program has been in effect for only seven and a half months, your Secretary is convinced that it has been worth many times what it has cost the Association. Its greatest value has been in the field of public relations. The public at large is beginning to realize that the South Carolina Medical Association has a progressive, long-range program for the state and that it is willing to spend time and energy toward putting the various parts of that program into effect. It has also shown the various organizations in the state that our Association is not only willing but anxious to cooperate in any movement which is aimed toward bettering the condition of the citizens of our commonwealth. As an example, note the splendid teamwork which has existed between our Association, the South Carolina Hospital Association, and other interested groups and individuals in the promotion of a "Blue Cross" plan for South Carolina. The leaders in the fight to secure the necessary enabling legislation have been Mr. Jacque Norman of the Hospital Association and our own Executive Director, the latter having served

as the Chairman of the Legislative Committee dealing with this problem.

To have a well trained and capable individual in another profession, and such is our Executive Director, to speak for our Medical Association has been both healthy and profitable. In his appearance before lay as well as medical groups, he has been able to explain the problems and possibilities of medical care in a new light and in a new language, and his effect upon these groups and upon individuals in conversation has been one which no physician, simply because he is a physician, could hope to obtain.

It might be noted that our Ten Point Program is creating considerable interest in other sections of the country. In the last news letter (April 7, 1945) sent out by the Council on Medical Service and Public Relations of the American Medical Association, we find the following statement, "Several months ago the *South Carolina Medical Association* instituted a 'Ten Point Program' to 'make available to all the people in the state, good medical and hospital care at prices they can afford to pay.' Dr. Julian P. Price, Secretary-Editor of the South Carolina Medical Association, 105 West Cheves Street, Florence, S. C., has prepared a *folder on the program* which everyone interested in medical public relations work should have. It is a comprehensive outline—pointing to a definite solution by a far-sighted, active and courageous medical society. Mr. M. L. (Jack) Meadors is the Executive Director and Counsel."

Your Secretary is convinced that if we, as an Association, hope to continue the work which we have started we should make the Ten Point Program and its Director a permanent part of our activity, and that we should make financial provision for so doing. Your Secretary is further convinced that the Executive Director should be tied in more closely with all of the work of the Association and not only with the Ten Point Program, so that his services would be available to any member or to any committee of the Association. Your Secretary would suggest, therefore, that the Executive Director of the Ten Point Program be made the Executive Secretary of the South Carolina Medical Association. This is in line with what many other state medical associations have done, and it has been found to be highly profitable.

LOOKING AHEAD

As your Secretary has attempted to study the trends of the times, he is convinced that the next few years—perhaps the next few months—will see profound changes in the broad field of medical care. Many of these changes may not be to our liking but that they are coming appears to be inevitable. A large number of the people in this country have not received the medical care which they need either because the care is not available or because they cannot afford it. Some plan must be evolved to correct this situation. It may be upon a voluntary basis, through prepayment for hospital and medical service, or it may be upon the basis of compulsory insurance. Many sections of the country need more hospitals, more health centers, more diagnostic and therapeutic clinics, more public health service. This broad expansion program may be worked out through the joint effort of various groups, including the medical profession, or it may be directed by one central agency. Many physicians will be needed to care for the indigent sick and for those in scattered rural communities where medical service is so scarce today. The problem will arise as to the method of procuring these physicians and of paying them. Will they be employed by the Federal government, the local government, or by joint action? Who will be

in charge of selecting and of placing these individuals?

These are but some of the problems which your Secretary sees as he looks into the future. He is no prophet and he cannot see beyond today. But of this he is sure—if the American Medical Association and if the South Carolina Medical Association wish to have a part in helping to make these plans they must once and for all cast aside the idea that all programs for medical care should be left in the hands of the medical profession. The man who needs medical care and the man who foots the bill (either as a taxpayer or as a private patient) is going to have his say. Physicians, individually and collectively, must be ready to work with others in the solution of all these problems. We must realize that, politically as well as socially, the needs and desires of the masses will ever transcend the needs or desires of the smaller group. By working with others and by thinking in terms of the needs of others, we may yet retain most of that medical tradition of which we are justly proud. By insisting on going our own way and by refusing to read "the handwriting on the wall," we stand to lose that freedom of individual enterprise which we hold dear.

RECOMMENDATIONS

In conclusion, your Secretary would bring together certain suggestions which he has made in this report and present them in the form of specific recommendations;

1. That the Ten Point Program be made a permanent part of our Association's activities, with adequate financial support.
2. That Council authorize the Treasurer to transfer an amount up to \$3,500.00 from the general fund to the special fund of the Ten Point Program to carry on the work of the Ten Point Program from September 1, 1945, to January 1, 1946.
3. That, at its next meeting, the House of Delegates raise the annual dues of the members of the Association from \$10.00 to \$20.00.
4. That in the event the House of Delegates is unable to meet this year, Council authorize the effort to secure \$6,000.00 from the membership through voluntary contributions to carry on the work of the Ten Point Program for 1946.
5. That the House of Delegates instruct Council to secure the services of an Executive Secretary of the Association whose duty it shall be to carry on the work now being done by the Executive Director of the Ten Point Program and also to work with any committee or individual of the Association who may desire his services.

Respectively submitted,
JULIAN P. PRICE, Secretary

REPORT OF THE EXECUTIVE DIRECTOR OF THE TEN POINT PROGRAM

To the Chairman and members of Council:

In accordance with your direction, the Ten Point Program was instituted on September 1, 1944. As of April 1, 1945, then, we have been in operation for a period of seven months—a sufficient time in which to orient ourselves, to observe and determine the directions which some of our most important efforts shall take, to realize some of the possibilities of the program, and to make beginnings. It is not sufficient time within which to achieve results which can be reported as accomplishments.

The several points which form the basic structure of the program provide the logical basis of division of this report, and will be taken up in order.

ADMINISTRATIVE

The offices already held by the State Association in Florence provided ample space and accommodation for the work under the program. Consisting of

two well-located rooms, one of which previously had been used principally as the Association Library, the headquarters of the program are well situated and arranged for the work of the Director and Office Secretary. A new desk and one filing cabinet were bought and proved to be the only additional furniture needed.

Because of the unusual demand for clerical help as the result of the war, some difficulty was experienced during the first few months in keeping an efficient secretary. The first employed resigned after one month, to move with her husband and family to Charleston. Realizing the uncertainty of their stay but being unable to do better, two wives of men at the Florence Army Air Base were then employed, in succession, with the result which was to be expected. The second left on December 28th to accompany her husband to another post to which he had been transferred. We were then fortunate in obtaining the services of a permanent resident, Miss Lillian Stokes, an experienced and efficient secretary who has been with us since, and whose assistance is highly valuable.

The library of publications of the various State and other medical Societies, the Journal of the A. M. A., and reports of government departments concerned with medical care, is practically complete. They are classified and arranged, so that the issues which are comparatively recent, as well as those current, are easily accessible. Several periodicals published by lay groups and dealing with the subject of medical care, particularly the economic side, are likewise on our shelves. Not all of these see eye to eye with the majority of the medical profession. We think it is well to keep informed of the thought, proposals and activities of our opponents and critics as well as in touch with the efforts of the profession as a whole.

I. COOPERATION

No opportunity has been intentionally missed to cooperate with or to offer our cooperation to groups, state government departments or otherwise, interested in the advancement and broadening of the scope of medical care.

Among our first official acts was the direction of letters to the State Health Department, the County Health officer in each county of the State, the Executive Secretary of the South Carolina Tuberculosis Association, the Chairman of the South Carolina Industrial Commission, the State Superintendent of Education and others in similar positions within the State Government and elsewhere, sending them copies of the program and requesting their cooperation in carrying out the various phases of the work.

The response to these letters was not large. Few replies were received from the various health officers although certain of the State Department heads wrote us expressing appreciation for the information and for the Association's efforts in instituting the program. On the whole, the opportunities toward active cooperation with other agencies interested in the furnishing of medical care have so far been limited but in one or two instances, to which reference will be made in detail in the proper place, we have been able to cooperate and have done so actively and with substantial favorable result. The important feature of this phase of the program is that, through the present organization, the State Association has the mechanism and holds itself in readiness to cooperate from time to time, as the occasion may arise, in various projects in the interest of the public from the standpoint of improved medical and hospital care.

II. POLITICAL CONTROL

Activity in this connection has been confined to the effort to inform ourselves fully of the develop-

ments in Congress in connection with the movement toward state control of medicine. The proponents of the Wagner-Murray-Dingell Bill have not been active during the months since our program was instituted. At least, their activity has been confined to areas outside the Congress and, in fact, it is clear that recent efforts have been in a somewhat different direction. Very recently Mr. Murray has reintroduced the Bill but without making any special effort to secure its consideration or passage and the general opinion at present seems to be that no concerted effort will be made in the near future to put across this particular legislation. For the time being, it is apparent that the greatest service that can be rendered along this line consists in informing the public as to what passage of the Wagner-Murray-Dingell Bill would really mean and of its far reaching effects on the population as a whole rather than as it relates primarily to the medical profession. We are firmly convinced that activity along this line will be profitable, that a well informed general public will realize, if it has not done so already, that the disadvantages attached to the administration of such an act and the type of medical care which would be generally available thereunder, will far outweigh any small advantage which might be realized by some small sections of the public.

The principal activities in Congress during the past year have centered in the work of the subcommittee, headed by Senator Pepper, of the Senate Committee on Labor and Education. This subcommittee, charged with the duty of investigating wartime health of the nation, has held a number of public hearings and has called to testify before it prominent leaders within and without the medical profession, officials of the American Medical Association and the American Hospital Association, outstanding leaders of business and capital, high ranking Army, Navy and Public Health officers, officials of the dental and nursing associations, and prominent national leaders of organized labor. These witnesses in their oral testimony and in the written statements issued by many, some of whom did not appear in person, have furnished the Committee with a cross-section of public opinion on the subject. Both sides of the argument have been presented. The viewpoint of organized medicine has been well represented, as has been that of the groups who believe that adequate medical care is not available and can never be under the present system of private practice. We have obtained and have in our files printed copies of all of the testimony and proceedings at the various hearings released so far, together with the two interim reports of the Pepper Subcommittee, which has not yet completed its full investigation. These reports are very informative and are repeatedly referred to for statistical information and for the statement of views of various individuals of national prominence; and they are of much help in our effort to grasp the overall significance of the movements of those who appear determined to bring about some considerable change in the method of administering medical care in the United States.

The attitude of the Subcommittee, so far as it can be ascertained from the comments at the hearings, the nature of the questions asked the witnesses, and the reports by the Committee, does not seem to be unduly biased against the profession. There appears to be a real desire on the part of Senator Pepper and the members of his committee to get to the bottom of the situation, to find out the facts and to propose a national plan which will be in the interest of the public as a whole, while taking into consideration the rights and the professional interest of the doctors. This in turn has encouraged a more tolerant view on the part of the medical profession. It is

a natural reaction to resent a dictatorial attitude and, on the other hand, to respond to an offer to work out the solution of any problem through discussion and mutual efforts of all concerned, through conferences where the parties may meet on common ground and discuss the issues as equals. The fact that the latter attitude seems to be developing is the most encouraging feature of the fight, with respect to state medicine, which we have been able to observe to the present time. As an illustration of this, we recall the remark of Senator Pepper at a recent conference in Atlanta. He referred to an attack which he said had been made upon him several months ago by the Editor of the *A. M. A. Journal*, and then went on to say that, following publication of his Subcommittee's interim report in January, the first commendatory message he received was from Dr. Fishbein and that the latter had complimented the Committee on its fair-minded consideration of the subject and its impartial approach to the effort at solution of the problem.

The attention of the lawmakers just now is being directed along a very different line from that which was taken a year ago. Although named as the virtually supreme administrator of the plan proposed under the Wagner-Murray-Dingell Bill, the Surgeon General of the Public Health Service, Dr. Thomas Parran, has never indicated any strong support of that plan and in fact, on more than one occasion, has clearly indicated that he is unconvinced of its efficiency. The best evidence of his feeling in the matter is his work in outlining and projecting into the picture an elaborate plan for the construction of hospitals in a nation-wide coordinated system. This, if carried out, would make available to people throughout the entire United States, regardless of location or number of people in any given community, at least some facilities for emergency hospital care, with a regular workable plan for treatment of the more serious cases and removal of those requiring specialized treatment to larger institutions where specialists would be available and where the advantage of every modern technical skill and appliance could be brought to bear. His plan was described by Dr. Parran in his testimony before the Pepper Subcommittee and set forth prominently in its report. Generally speaking, and so far as we know of it now, there appears to be much to be said in its favor. It does not appear that the plan would contemplate setting up government owned and controlled hospitals in competition with private and eleemosynary institutions now in existence but that these facilities, to as large an extent as possible, would be brought into the system and utilized. The plan includes assistance in the educational and research activities of medicine, the Regional Health Center in each state, or other such geographical unit as might be determined upon, with a hospital operated in connection with a medical school and having not only all facilities but likewise an abundant supply of cases of various kinds which would serve for the purpose of study during treatment and the opportunity for the further scientific development of medical and hospital technique.

One of the most interesting and commendable features is the plan for health centers in the smallest communities, where a real hospital would be neither possible nor necessary. These centers, together with the facilities to be furnished for bringing the patients to them, would be equipped to take care temporarily of emergency cases and to feed these on into the larger hospitals when necessary. The plan in this connection is somewhat similar to that by which the wounded are taken care of in the areas of military action—from the first aid station to the

receiving hospital and from there to the base hospitals and back to the institutions in England and the United States.

Of course, the system suggested by Dr. Parran would require a large measure of federal control both for the financing of its construction and administration and also for the purpose of coordination of its activities, this being one of the principal aims to be accomplished, since it must be borne in mind that the Congress will try to evolve some plan which will assure the greatest amount of medical care to the greatest number of people at the least possible cost and inconvenience to them.

Still another project is under consideration. At the conference in Atlanta at which Senator Pepper talked, he outlined a plan of national voluntary insurance against the hazards of illness and hospital treatment. Under this plan, there would be set up in each state some particular agency to function with the help of an advisory council composed of representatives from the medical and other professions and of the various groups of business, industry, labor and government. Participation in the plan would be entirely voluntary and rates of payment by the subscribers would be graduated according to the income of the individual. It appears to be generally a broad development of the principles on which the Blue Cross plans and a number of medical service plans throughout the country are now operating. Since membership would be voluntary and subscription rates graduated according to income, it is obvious that those in the higher brackets would be less interested in participating and that in all probability the income from subscription payments of the subscribers with small incomes would be insufficient to finance the organization. The amount therefore would be made up by government subsidies and this, in turn, as well as the requirements for proper administration of a coordinated system on a national scale, would require a large measure of supervision by the federal government. According to Senator Pepper, he does not envision any direct control or dictation from bureaus in Washington but the money and the supervision both would be administered through the designated agency in each State, acting in cooperation with its advisory council.

It would be useless to hope for any system of providing universal medical and hospital care without help in a financial way from the government, either state or federal. Both are already well tied into practically every similar project now in operation for dealing with special conditions. The profession generally has recognized this and has urged that whatever federal control or assistance is offered should come through the States. The proposals of both Dr. Parran and Senator Pepper seem to be largely in accord with this line of thought; and we believe, at least, can be said therefore to be steps in the right direction.

III. STUDY

The activities along this line have been covered to a large extent under the remarks above. However, in addition to a study of the Committee reports and testimony, we have kept in touch with the activities of other State Associations and informed of the developments in the hospital and medical service plans which are in operation elsewhere. Reference has been made already to the complete file maintained of medical journals and other literature, both lay and professional, which deal with the economic side of the practice of medicine.

Statement of the aim under this third point of the program included the purpose to inform ourselves on the extent of medical care now available and the additional needs. The time required for activity in connection with other phases of the work has not per-

mitted a great deal of attention to this so far. However, detailed study has been made of the administration and operation of the Blue Cross plans, the several medical service plans and the work of certain commissions on medical care, especially of the State of North Carolina. There have been also a number of analytical studies of certain phases of the subject in this State, particularly those of Dr. A. M. Lassek of the Medical College of South Carolina. These have been most helpful in forming the basis of a preliminary understanding of the situation with respect to distribution of physicians and the trend in medical education in South Carolina. Most of these studies were published in the *Journal of the Association* from time to time within the past two or three years and we feel that Dr. Lassek's efforts will be most helpful in forming the basis of any concrete action which the Association may decide to take in connection with a number of the phases of the program.

In our study, we have conceived it to be our duty not simply to learn the viewpoint of the profession itself but to obtain as broad outline as possible of public opinion generally on the subject. The lay publications have carried many articles relating to this matter and have offered some helpful suggestions. It is our purpose to continue this sort of study and to be in position, so far as possible, to understand the viewpoint of the "man in the street." The more we study, the more we are convinced that the best solution of the problems before us can be worked out only in this way.

IV. CARE OF THE INDIGENT

Shortly after the program was instituted, letters were addressed to the State Senator in each county in South Carolina requesting information on the method of dealing with medical care of the indigent in the respective counties. From the forty-six thus contacted, thirty-one replies were received. A number of these were full and furnished adequate information for an understanding of the county system. Others were not so satisfactory and so far it cannot be said that any very concrete idea has been developed toward a state-wide plan for dealing with this subject. It is well known that certain of the counties are dealing with the matter splendidly while others, for various reasons, have little provision or unsatisfactory methods. It was our thought that there might be gleaned from a comparison and combination of the different plans some one idea which might be recommended for adoption throughout the state as a whole. Whether or not this will be practical remains to be seen. Undoubtedly it will have the disadvantage of being opposed in many quarters for political reasons. Many of the law-makers feel that the plans already operating in their respective counties are doing a good job. In some instances, these are the "brain children" of the legislators themselves and they feel personal interest in them and a natural jealousy in any movement toward change. Perhaps our efforts along this line will be best directed toward encouraging and cooperating with the counties where the provision is now inadequate, in their efforts to bring themselves up-to-date and, later, in recommending additional appropriations by the Legislature to supplement funds now available under the various county acts.

No effort was made to work out any plan to be submitted to the Legislature at its 1945 session. We felt that the length of time and our information so far had been entirely too limited to permit doing so on any intelligent basis and that other features of the program were more pressing at the moment. The indigent are already recognized as the care and responsibility of the State as a whole, and they are

being cared for to some extent practically everywhere although, in many cases, inadequately. Other groups of the population do not require the same sort of assistance but do deserve attention and it is of the greatest importance that this attention be given them immediately.

V. HOSPITAL INSURANCE

Our page in the *Journal* during the past few months has carried a detailed running account of the efforts to secure passage of the enabling act for the proposed "Blue Cross" plan. The hospital insurance contemplated under Point 5 of the program is not confined to the type provided for under the "Blue Cross" plans, but the purpose in this connection is to encourage the use of any sort of hospital insurance so long as the same is voluntary. However, the program does state the intention to make available to all the people particularly that type of hospital insurance which is sold on a non-profit basis. It was generally understood, therefore, that the "Blue Cross" type was in contemplation. This plan has the merit of having been tried in nearly all parts of the nation under every sort of geographical and occupational situation and has met the tests from the standpoint of financial soundness, adequate service and substantial benefit to the subscribers. The general supervisory authority maintained over the numerous individual plans by the Hospital Service Plan Commission of the American Hospital Association assures a uniformity of standard along operational lines which is highly desirable in a project of this kind.

The effort to bring South Carolina in as the 43rd state offering "Blue Cross" service has not been easy. In view of the information carried in the recent issues of the *Journal*, to which reference is made above, it does not appear necessary to recount in detail here all that has been done. Briefly stated, this is what has taken place so far. In November, preparatory to our work in this connection, the Program Director accompanied the Secretary of the Association to Chicago for the meeting of the Editors and Secretaries of the State Journals and Associations. While there, he took advantage of the opportunity to visit the headquarters of the Hospital Service Plan Commission and to interview personally Dr. Rorem, its Executive Director. The conference was of much benefit since it afforded the opportunity to ask many questions and obtain a quantity of information which would have been difficult to acquire through a mere study of printed material. We returned with a fairly clear idea of the general purpose and plan of the "Blue Cross" organizations and firmly convinced of their value as public service institutions and as a means of helping to preserve the existing system of medical practice and hospital treatment.

Previous to the Chicago trip, we had been in contact with Dr. V. P. Patterson, President of the South Carolina Hospital Association and Mr. J. B. Norman, Chairman of its Legislative Committee and Superintendent of the Greenville General Hospital. We were thus aware of the efforts which had been made by the Hospital Association last year to secure passage of this legislation, only to have it pigeon-holed in one of the Committees of the House of Representatives. On November 30, 1944, a meeting was held in Columbia which had been arranged by Mr. Norman and Dr. Patterson and which was attended by a majority of the members of a proposed directorate or Board of Trustees for the "Blue Cross" plan in South Carolina. The meeting was held at the Wade Hampton Hotel and was addressed at length by Mr. J. E. B. Stuart, Executive Director of the Cincinnati plan, one of the largest in the country. All of those present had the opportunity of learning

much about "Blue Cross" from his full and clear explanation. Officers were elected, headed by Mr. T. C. Callison of Lexington and Columbia as President. A Legislative Committee was formed, of which your Program Director was subsequently named as Chairman. This Committee and others of the more interested members of the group which met in Columbia on November 30 formed the spearhead of the attack which was launched in the first days of the session in January for the passage of the bill and which has continued the battle—and we use the word advisedly—up to the present time.

The bill was introduced as that of the Committee on Medical Affairs of the Senate on January 19 and was referred to the Committee on Banking and Insurance. That Committee held a public hearing, at which proponents and opponents were represented, and reported the bill favorably a few days later. On motion of one of the Senators, it was recommitted and another public hearing was held by the same Committee and a number of amendments were agreed upon. The bill was then again reported favorably to the Senate and, after some further debate, was passed on second reading without most of the amendments which the Committee had recommended. In the early days of March, the bill finally passed third reading in the Senate and went to the House where it was read the first time on March 14, 1945. It was referred to the Committee on Medical Affairs of the House which promptly met and rendered a unanimously favorable report but, on being returned to the Speaker's desk, the bill was referred to the House Committee on Banking and Insurance. A determined effort to postpone consideration by this Committee until April 4 was overcome and a public hearing held on March 28. On this occasion, a full dress debate between the advocates and opponents of the bill took place before the Committee, resulting in a majority favorable report by the Committee immediately following the hearing. Our friends were successful in having the bill made a special order of business for Thursday, April 5, at which time debate was commenced but was interrupted by adjournment and ordinarily would have been resumed on Tuesday, April 10. On the latter date, however, the pressure of previous business on the calendar prevented this bill from being reached and, at the urgent insistence of the Governor and the leaders of the House, consideration of the bill to create an Alcohol Board of Control intervened and took precedence over all other legislative business in the House. Apparently then, further consideration or action upon the "Blue Cross" bill must await disposition of the so-called "Liquor Bill" and as the prospect of adjournment looms ever nearer, it is impossible to say at this time whether passage can be secured at this session.

Perhaps some idea may be read between the lines of the foregoing of the opposition we have been up against. There has been and is a determined lobby on the part of a very few small insurance companies engaged primarily in writing hospital insurance. Most, if not all, of these are South Carolina corporations and, since the bill has been in the House, the most determined efforts can be attributed almost solely to a single company which seems to fear the effects of "Blue Cross" insurance above everything else. Despite these efforts, we are firmly of the belief that if the bill is ever reached for a vote in the House, it will be passed with a good margin to spare. The dilatory tactics and the various proposals advanced repeatedly in the effort to sidetrack the measure are further proof of this fact. Whatever may be the outcome, the proposed act has progressed much farther this year than at any time in the past and the South Carolina Medical Association is wholly justified in taking the lion's share of the credit. The

outspoken endorsement and support of the Association and the activity and personal efforts of a number of the doctors has had immeasurable influence in getting the bill this far. It can result in the bill's complete passage even though this may not be completed until the session of 1946.

By far the greater part of our time and attention since January 1 has been devoted to the "Blue Cross" bill. Numerous letters have been written, printed material sent, telegrams and telephone messages transmitted and trips made to Columbia with a regularity almost unbroken. The most positive action under the program thus far has been devoted to this, which appeared to be the logical first step.

VI. HOSPITALS

The National Commission on Hospital Care, organized through the efforts of the American Hospital Association, inaugurated last year an effort to secure a nation-wide coordinated survey of existing hospital facilities, needs and outline of hospital expansion. On our visit to Chicago in November, we discussed the matter at length with Dr. Bachmeyer and the members of his staff in charge of the survey and obtained a good idea of what was proposed.

On January 10, 1945, Senator Hill and Senator Burton introduced in the United States Senate a bill to amend the Public Health Service Act for the purpose of authorizing grants to the states for making such surveys and also to provide for the construction of hospitals in line with the needs which should be found to exist.

All of this was directly in line with Point 6 of our program which is "to study the present availability and facilities of hospitals in the state and to promote the establishment of well-equipped and adequately-staffed hospitals in needy areas." This seemed therefore a splendid opportunity to activate in a positive manner, another phase of the program.

After mature consideration and discussion with Dr. Cain, Dr. Wallace and other officers of the Association, and in conjunction with Dr. Patterson, President of the State Hospital Association, we approached the Governor with a proposal for the appointment by him of a Commission for the purpose of making plans for such a survey. It was suggested that the Commission consist of representatives of the medical profession, hospital men, representatives of the State Board of Health and of various branches of business, industry and other representative groups. Governor Williams indicated his approval of the general idea and invited further discussion of the matter. Before this could be taken up with him again however, a bill was introduced in the Senate providing for the making of the survey in South Carolina by the State Board of Health. This bill provides for the appointment of an advisory council with membership from generally the same groups as we had contemplated. In view of the introduction of this bill, no further contact was made with the Governor in an effort to carry out the original idea since, obviously, such a Commission as we had proposed would have resulted in a duplication of effort if the survey along the same line is to be made by the State Department of Health. At the present time, the bill has not been passed by the Legislature but we are holding ourselves in readiness to cooperate fully and to extend any assistance that we can in any survey that is made.

In December, the beginning was made of a study on our own of the use being made of existing hospital facilities in the state. Questionnaires were mailed to all of the general hospitals in South Carolina requesting their figures on the number of patients admitted from each county in three representative months of the previous year. Thirty-four hospitals responded and gave us this information. Of course,

in practically every case, the greatest number of patients was from the county in which the hospital is located. The study of the figures has not been completed but, from the progress made so far, it appears that even this small effort will serve to indicate important trends in the matter of supply and demand for hospitalization in the state.

No effort has been made to carry into effect the second part of the sixth point relating to the subject of hospital standards.

VII. GROUP HEALTH INSURANCE

With the exception of obtaining information from the office of the State Insurance Commissioner and from the South Carolina Industrial Commission, relative to the type and extent of group health insurance plans now in effect in South Carolina, and our discussions with the heads of certain representative industries in the state relative to the group plans in operation within their individual organizations, no action has been taken with respect to group health insurance.

VIII. STANDARDS FOR INSURANCE

No effort has been made to initiate any action on this subject.

IX. MEDICAL AND NURSING EDUCATION

In view of the recently instituted expansion program of the Medical College of South Carolina, launched and now in progress under the direction of its Board of Trustees, no independent action on our part in this connection seems to have been indicated at this time.

X. EDUCATION OF THE PUBLIC

With the possible exception of the "Blue Cross" plan, and certainly if we include the effort to inform the people concerning it, by far the major portion of our activities since the inauguration of the program has been devoted to the task of public education as to the aims and interest of the Association in the various aspects of medical care. We have undertaken to reach the largest number possible through the newspapers, the radio and by talking at every organized gathering where the opportunity was presented.

On Sunday, September 2, the institution of the program was announced in all of the daily newspapers of the state and this was followed by similar announcement in the afternoon papers in the ensuing few days. Some reaction was immediate. Within the following week, an invitation was received from the Program Director of Radio Station WIS to participate on a public forum discussion of the subject on Sunday, September 17. Dr. Julian Price, Dr. Hugh Wyman and Dr. Gordon Spivey, along with your Director, took part in the discussion which was broadcast for a half hour and in which the salient points of the program were taken up and discussed. This discussion was followed up by another on the same subject the following Sunday by four laymen representing business, organized labor and agriculture.

Additional radio talks were made on the program by Dr. Price over Station WAIM at Anderson on September 25 and by your Director over Station WFBC at Greenville on September 26. In the effort to fully acquaint the profession itself with the program, we have talked at the meetings of nine societies in as many counties of the state, including Anderson, Columbia, Charleston, Spartanburg, Florence and others. We have spoken in every district except the third and seventh. In addition to these efforts within the profession, we were invited to speak at the South Carolina Conference on Social Work at its annual meeting in Columbia on October 26 and to the South Carolina State Hospital Association at the Wade Hampton Hotel in Columbia

on December 1. Both of these talks were well received and the response gratifying. The State Hospital Association went on record in an apparently unanimous endorsement of the Ten Point Program.

Talks have also been made to the following other lay organizations or groups:

Civitan Club, Mullins, S. C., Rotary Club, Timmonsville, S. C., Kiwanis Club, Darlington, S. C., Lions Club, Conway, S. C., Lions Club, Florence, S. C., Kiwanis Club, Florence, S. C., and the Rotary Club, Bennettsville, S. C.

From time to time, at irregular intervals, news releases and articles have been sent to the daily papers and weekly periodicals. A good deal of interest has been indicated by people outside the profession and this interest seems to be concentrated chiefly upon the fact that the medical profession has taken an active stand and is making positive, rather than negative efforts, to solve its problems. The sources of interest have not been confined within the state but a number of inquiries have been received from organizations in other states and within the past week requests have been received from the Medical Societies of the states of New York and Pennsylvania for copies of the Ten Point Program. We feel that, on the whole, the public generally in South Carolina and the medical profession in other states as well, are aware that here, at least, we are trying to move forward in a constructive manner.

RECOMMENDATIONS

We believe the reaction to our efforts thus far on the part of the profession and the general response of the public and particularly of the legislative branch of our State Government, justifies the continuation of the program along the same lines that have been followed to this time. The further we have progressed, the more additional channels for positive action have opened up and, undoubtedly, this will continue to be the case. We are unaware at this time of any additional steps that might have been taken within the first few months but, needless to say, so far the surface of possibilities has hardly been scratched. One result alone which is sufficient to justify the effort so far is the bringing together in closer cooperation of the Medical Association and the Hospital Association in South Carolina. We would recommend further definite progress toward full cooperation and understanding between these two groups, the purposes, aims and interests of which are so closely allied.

Obviously, the effect of what the South Carolina Medical Association can do in the national effort to prevent socialized medicine depends almost entirely upon the extent to which its efforts are coordinated with those of the societies in other states and with the national organization. There are ample signs that we are gaining recognition. It is a coincidence that, even as this is prepared, a number of letters from states as far away as Michigan, New York and Pennsylvania are coming to our desks with requests for copies of the program, these inquiries resulting from the reference in the April 7th issue of the AMA news letter. The best means of understanding and exchanging ideas along these and other lines is through personal contact at the various regional and other conferences from time to time. Therefore, we believe that, if the program is to be continued, provision should be made for our attendance at many of the more important of these meetings. It will serve not only to keep us in touch with and abreast of the developments throughout the nation, but will assist in gaining further recognition of the pioneer efforts being made by the South Carolina Association.

Respectfully submitted,
M. L. Meadors

REPORT OF CHAIRMAN EXECUTIVE COMMITTEE OF STATE BOARD OF HEALTH

This year has been characterized by change. As reported to you at the meeting of the House of Delegates last April, Dr. James A. Hayne was relieved of the arduous duties of State Health Officer after a third of a century of successful service and Dr. B. F. Wyman was elected to this position.

Dr. Wyman began his duties on May 1, 1944, and has carried on in his new position with zeal and enthusiasm. Many innovations and combinations have been effected which will save considerable money for the taxpayers.

We are glad to report that the valuable experience of Dr. Hayne will not be lost to the Department. He has been retained as the Director of the Bureau of Public Health Education. We are sure he will render the State many more years of valuable service.

At the September meeting of the Executive Committee Dr. Kenneth Lynch, on account of pressing duties at the Medical College, tendered his resignation as Chairman. His resignation was received with genuine regret and he was commended for his splendid work as the presiding officer for several years. The Vice-Chairman, Dr. W. R. Wallace, was elected to fill out the remainder of Dr. Lynch's term of office and Dr. Walter Meade was elected Vice Chairman.

The war has continued to make many problems in the matter of personnel but by each division taking on additional duties the efficiency has not been impaired seriously. We wish to commend the spirit of loyalty and cooperation of all the employees during this trying period.

It is a matter of pride and satisfaction that we have passed through another year of war without a major epidemic of any kind. We feel that constant vigilance on the part of our force of health workers has contributed largely to this splendid achievement. Although there was a very widespread epidemic of poliomyelitis in an adjoining state, the number of cases in South Carolina, while increased above normal, did not reach epidemic proportions. It is interesting to study the measures taken to prevent the spread of this malady and to try to evaluate quarantine measures used.

For several years the Board has been studying the question of purchase and finance. We feel that plans have been adopted which will do much to expedite the purchase of supplies and material and also will save money.

While the funds of the State Health Department are budgeted, checked and audited both by State and Federal officers it was thought best to set up a Division of Finance. This important division will be under a director who will be a person trained and competent to handle business affairs of the magnitude to which the State Board of Health has attained. Mr. John O. Meetze has been secured to fill this very important office and entered upon his duties April 2, 1945.

Your Board has taken an active interest and supervision of the Rapid Treatment of venereal diseases at the Quarantine Hospitals. We feel that much good has been done by returning so many to health in such an incredibly short time. The use of the sulfa drugs, penicillin and rapid administration of arsenical under the U. S. Public Health service has given a splendid opportunity here in South Carolina to prove the value of these newer drugs and the best method of administration. Unfortunately the River Side Hospital was burned Feb. 7, 1945, but fortunately with no loss of life or injury of any kind. The United States Government is being con-

tacted to find out the plans for continuing this important work.

An experimental work in the use of DDT spray is being carried on in eleven of the counties in the lower part of the state. This powder has been used very successfully by the Military Authorities. We believe it will be demonstrated here in South Carolina that it will be equally effective in ridding civil communities of malaria. \$130,000 is being expended by the United States Public Health Service.

The method of handling biologicals has been changed. The E. R. Squibbs & Sons who were again the lowest bidder on most of the products distributed according to the regulations of the budget for this purpose, now have their own office and storage room at _____ Street. All drugs and biologicals are bought on competitive bidding, the contract going to the lowest bidder.

The bureau of Vital Statistics has had an extremely increased load to carry during the war period. This department with the aid of newer methods and mechanical devices has kept up with the increased demands and has done a fine job.

The Laboratory has also had an increased load but has carried on in an efficient manner and this department is to be commended.

Your hospital for tuberculosis at State Park continues to do a magnificent work. The labor shortage has been a perplexing problem. There has been great difficulty in replacing doctors at the Sanatorium who were called into service or other fields of endeavor.

In all we feel that splendid work has been done in preventive medicine and this has aided in the better mortality and morbidity rates in the state. Deaths from cancer and degenerative disease continue to rise.

The complete record of the activities of the State Health Department is printed in booklet form and covers some 250 pages. We trust you will avail yourselves of a copy that you may know the increasing duties and activities of your Board of Health.

W. R. WALLACE, Chairman
Executive Committee of the State Board of Health.

REPORT OF MEMORIAL COMMITTEE

The following physicians, our colleagues, have died since the last meeting of the S. C. Medical Association.

Dr. F. G. Asbill, Ridge Spring
Dr. F. A. Blanchard, Bishopville
Dr. A. E. Boozer, Columbia
Dr. R. C. Bruce, Greenville
Dr. B. C. Caughman, Columbia
Dr. J. L. Donnon, Ware Shoals
Dr. G. B. Frey, Spartanburg
Dr. R. M. Fuller, Greenwood
*Dr. F. R. Lawther, Moncks Corner
Dr. H. E. McDowell, Spartanburg
Dr. James H. McIntosh, Columbia
Dr. F. H. McLeod, Florence
Dr. C. J. Miller, Inman
Dr. C. E. Owens, Columbia
*Dr. John W. Speake, Jr., Spartanburg
*Dr. Joseph Barr Traywick, Holly Hill
Dr. C. B. Earle, Greenville
Dr. B. A. Henry, Anderson
Dr. Samuel Friedheim, Rock Hill
Dr. James R. Hopkins, Hopkins
Dr. Robert L. McCrady, Charleston
Dr. Dave Porter, Andrews
Dr. Wm. H. Carrigan, Summerton

*In service. Respectfully submitted,
Dr. T. R. Littlejohn

From the Retiring President

The South Carolina Medical Association has operated for the third year under restrictions incident to war. We find some of its activities cancelled and others postponed. This is not a complaint but an explanation. There has been no wavering of the will to win this war at the earliest moment on the part of the medical profession and so the governmental restrictions are received with a liberal amount of good grace.

The first major disappointment was the order of O. D. T. which plainly cancelled the general session and the Scientific Program of our Association. We still had hopes that the House of Delegates could meet but we were held to an attendance of not more than fifty. A meeting was contemplated with a restricted attendance and using proxies of the other delegates. This did not seem to be in accord with our Constitution and By-Laws. It is hoped that restrictions will be removed before the end of 1945 and that a meeting of the House of Delegates can be held. A meeting of the Council was convened on April 17, 1945 at 2:30 p. m. to hear the reports and transact all business compatible with their powers and prerogatives. We feel that the affairs of the Association will be well taken care of for another year by your officers and the council and that progress will continue to be made.

It seemed to be for the best interest of organized medicine that the President-elect should take over and his successor be elected when the House of Delegates have an opportunity to meet.

✠ As your retiring President I want to take this means of expressing to every member of the South Carolina Medical Association my very deepest gratitude for the honor of having served as your president. Your courtesies and your loyalty are deeply appreciated. My very best wishes go out to each of you and my loyal support to my successor. My best efforts and devotion shall always be for the best in organized medicine in our beloved state.

W. R. Wallace

The Journal of the South Carolina Medical Association

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 Florence, S. C.

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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

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COUNCIL MEETING

"Between the regular meetings of the House of Delegates, the Council shall serve as the Executive Committee of the Association"—(By-Laws, South Carolina Medical Association, Chapter VII, Section 6.)

When war-time restrictions prevented an annual meeting of the House of Delegates this spring, it was incumbent upon Council to carry on the work of the Association and to make provisions for the future.

Council held its annual session on April 17th, therefore, and a report of the meeting is published elsewhere in this issue.

The task which faced Council was no easy one. Council did not know—in fact, no one knows—whether it will be possible to hold a meeting of the House of Delegates this fall or whether the next meeting will be held next year. Our Constitution and By-Laws were written and adopted in terms of an annual meeting of the House of Delegates and make no provision for a course of action in the absence of such a meeting. The South Carolina Medical Association is a corporation, incorporated under the laws of the state of South Carolina, and as such must operate within the provision of its Constitution and By-Laws.

The members of Council were fully aware of the responsibility which rested upon their shoulders as they met in Columbia. All questions were discussed at length and actions were taken only after full deliberation. In practically every instance, the decisions were unanimous, and the decisions were reached with this one thought in mind, "Is this for the best interest of the Association?"

We urge that each member of the Association read carefully the account of the meeting of Council with the reports of the Secretary, the Director of the Ten Point Program, the Executive Committee of the State Board of Health, and the Memorial Committee.

OUR NEW PRESIDENT

Dr. W. Thomas Brockman of Greenville, was installed as President of the South Carolina Medical

Association at the recent meeting of Council.

A native of Spartanburg County, Dr. Brockman was graduated from Furman University and from the Medical College of the State of S. C. (1909). Beginning his career in medicine as a general practitioner in Greer, he devoted his time and study to proctology and since 1926 he has lived in Greenville and has limited his work to that specialty. He is a Fellow of the American Proctological Society.

In addition to his professional work Dr. Brockman has been keenly interested in medical affairs in general and in various civic enterprises. He has been president of his county and of his district medical societies and for a period he served as the mayor of Greer.

During the past year while he served as President-Elect, Dr. Brockman has worked diligently. He has visited most of the district societies, has sat in on numerous committee meetings and has appeared before committees of the state legislature on several occasions. He has shown a vision and an aggressiveness which speaks well for the work of the Association during his year of leadership. We wish him well and ask for him the support of every member of the Association.

COURAGE AND DEVOTION BEYOND THE CALL OF DUTY

There came to our desk recently, as a gift of the Mead Johnson Company, a small book listing a partial record of official citations to medical officers in the United States Armed Forces during World War II. No physician can read its pages without a sense of pride in his profession and a sense of gratitude and admiration for our colleagues in the service.

As we turned the pages and noted the names of those who had been honored, we found listed there four of South Carolina's own;

Lieut. Bothwell Graham, III, of Clinton, was awarded a Presidential Unit citation. He served as battalion surgeon with the First Marine division in the conquest of the Solomon Islands. He also served as assistant battalion surgeon with the Fifth Defense battalion supporting Col. Carlson's Raiders' offensive in the eastern landing on Guadalcanal.



W. Thomas Brockman
President
South Carolina Medical Association
1945-1946

Lieut. Comdr. Ben H. Keyserling, of Columbia, was awarded the Silver Star Medal.

"While his unit engaged with the enemy, Commander Keyserling displayed a high degree of courage, initiative and professional skill under the most hazardous of conditions.

"Dr Keyserling, after all available stretchers had been evacuated to the rear with wounded, advanced to within a few yards of the front line assault companies, coolly and expertly treated wounded as they fell and evacuated them to the rear under heavy machine gun and rifle fire, for a full half hour."

Capt. Emory C. Kinder, of Kingstree, was awarded the Soldier's Medal in England where he is a flight surgeon with an Eighth AAF Flying Fortress group. Dr. Kinder was decorated for heroism in risking his life to save a wounded gunner who was pinned in a flying fortress by a live bomb which entered the tail of the plane. After the fortress landed with the bomb embedded in its tail Dr. Kinder entered the ship and freed the tail gunner, although the bomb was in danger of exploding any moment.

Lieut. Charles C. Smith, of Charleston, was awarded the Silver Star for gallantry in action. The citation accompanying the award read as follows: "On the 10th of July, 1943, the ship on which First Lieutenant Smith was a passenger was bombed and strafed by German planes as it prepared to beach near Licata, Sicily. One half-track was set afire and Lieutenant Smith directed and personally assisted the fire-fighting crew. He spent the remainder of the day inside the ship caring for the wounded, completely disregarding further bombing and strafing attacks. His calm, courage, absorption in duty in the face of danger, and above all his coolness under fire, were an inspiration to all army and navy personnel on board and helped immeasurably in the sustaining of a high morale during a difficult operation."

From the Associated Press:

"Captain P. M. Kinney, of Bennettsville, who is serving overseas with a medical collecting company, has received a Presidential Citation for work on the beach of Normandy in June. The Citation was issued last September but was just received.

"Dr. Kinney has three stars in the European theater of operations ribbon for the campaigns of Normandy, France and Germany. He also has a Bronze Indian Arrowhead for having made an initial assault landing."

From The Bulletin of the Greenville County Medical Society:

"Capt. Henry Clay Robertson, Jr., of Charleston, was recently awarded the Oak Leaf Cluster in Germany for meritorious conduct on the field of battle. It was indicated that this was during action in the Hurtgen Forest early in December. Dr. Robertson

had already been awarded the Bronze Star in October during the Brittany campaign."

IMMUNE SERUM GLOBULIN

Immune serum globulin may now be obtained by physicians from the State Board of Health. A story concerning this may be found under the Public Health section of this issue.

So that physicians may know just what this material is and for what purpose it is used we are printing a statement prepared by Dr. C. A. Janeway of Harvard Medical School.

Normal Serum Gamma Globulin Antibodies (Human) Concentrated (Immune Serum Globulin)

1. *What is this material?*

This preparation is a concentrate containing the antibody globulins derived from pooled normal human plasma collected by the American Red Cross.

2. *What is its potency?*

Preparations of Gamma Globulin Antibodies are standardized so that the concentration of antibody is 25 times that of the plasma pool from which it came. Since each pool is obtained from several thousand donors, variations in titer of measles antibody should be slight. Each preparation is tested for potency in the laboratory by tests for antibodies which can be readily measured. Whenever possible its potency is checked in a series of patients exposed to measles before release for general use.

3. *Stability*

This material should be kept in the icebox like other biologicals. The dating period at present is set at one year. It is probable that it will retain its potency for longer periods of time.

4. *Indications*

At present this material is released *only* for the prevention and modification of measles by passive immunization. Other possible uses are being studied, but insufficient data are available to evaluate its efficacy in these circumstances. Its use in the treatment of measles or the treatment of prophylaxis of other childhood diseases is not recommended at present.

5. *Administration and dosage*

This material may be administered when indicated to patients who have had a definite exposure to measles in the infectious stage. Its use to prevent or to modify the disease is at the discretion of the physician.

For prevention—A dose of .08-.1 cc./lb. body weight should be given as soon after exposure as possible, but will be fairly effective in the first seven days.

For modification—A dose of .02-.025 cc. lb. body weight should be given on or about the fifth day after first definite exposure.

Method of administration—The globulin is injected *intramuscularly*, preferably in the buttocks. For this, a 20- or 21-gauge needle is most satis-

factory. Pull back on plunger of syringe before injection to be sure needle is not in vein, *since globulin as now prepared must not be used intravenously.*

Caution—The globulin is a concentrated protein solution, hence viscous and sticky. Do not fill syringe until prepared to make injection, otherwise syringe may become frozen.

Jaundice—Blood, plasma, and serum have been found on occasion to contain a jaundice-producing agent. Therefore, it is possible that fractions derived from plasma may contain a similar agent. Such jaundice appears 2-6 months after injection. No jaundice has been attributed to this material so far, but careful records of its use should be kept so that any cases of jaundice occurring 2-6 months after injection may be traced to the particular lot concerned.

6. Safety

A great many *intramuscular* injections have been given without any serious reactions and with very little local pain in the dosage recommended. Rarely, fever, irritability, or tenderness of the site may fol-

low injection in the first 24 hours.

7. Duration of effect

A single dose will probably protect a child for about 3 weeks. At the end of that time, if the child is re-exposed and protection is desired, the dose should be repeated.

8. Results of injection

With any biological system, in which the virulence of the virus and the resistance of the host may vary considerably, some variation in results is to be expected. With the small doses used for modification, a few patients will develop typical measles; with the large dose, used for prevention, a certain number will fail to develop any evidence of measles.

Mild measles which results from a satisfactory modification may vary from a disease only slightly milder than the average case to one that exhibits only one or two of the stigmata of measles. Malaise and fever are usually markedly reduced, the catarrhal symptoms slight, and rash may be evanescent and sparse.

NEWS ITEMS

The Coastal Medical Society held its monthly meeting in the Glass House Restaurant at Walterboro on March 15, 1945, with Dr. J. N. Walsh of Moncks Corner presiding. The meeting was called to order and the minutes of the previous meeting were read and approved.

Dr. Walter Bristoe of Columbia read a very interesting and instructive paper on "eye lesions of general interest." He discussed each subject; including diagnosis and treatment, clearly and succinctly, demonstrating each with lantern slides. His paper was thoroughly enjoyed by all and discussed by Drs. Palmer, Walsh, Bennett, and Black.

Dr. George Bunch of Columbia then gave a most interesting discussion on "The Diagnosis and Treatment of Ruptured Peptic Ulcer." The subject was discussed by Drs. Baker, Bennett, Johnston, and Ritter.

Dr. J. W. Chapman gave a very interesting talk on "tropical diseases" stressing the fact that we should be on the alert for these conditions as the men returning from the various theaters of war would probably be carriers of some of these rare diseases. His subject was discussed by Drs. Bailey, Bristoe, and Black.

A delightful steak dinner was served at the conclusion of the scientific program.

Dr. and Mrs. C. P. Vincent, Jr., of Camden, announce the arrival of a son on April 5, 1945.

"FAITH AND GUTS"

From the 100th Division in France has come a story of the "faith and guts" of two medical officers and an aid man. Twice one night the aidman, Pfc. Julius Shocko, of Charlevoix, Mich., had attempted to reach a casualty, but German machine gun fire raked the intervening terrain. Later Shocko was joined by Captain James F. X. O'Rourke, MC, of New York City, Battalion Surgeon, and 1st Lt. Leonard E. Coplen, MAC, of Newton, Mass. The three boldly walked out in the day-light and covered 300 yards under German observation while the men in foxholes held their breath. At the edge of some woods they were stopped by a German gunner. "We are from the Medical Corps and we have come for the wounded man," they told him. After a short wait several Germans appeared carrying the body of the man they had sought to rescue. "You have great courage," said one of the Germans as the medical men started back with their burden.

DEATH

Dr. W. H. Carrigan, 58, died suddenly at his home in Summerton on April 16. A graduate of the Medical College of the State of South Carolina, Dr. Carrigan served for several years as a member of the staff of Roper Hospital in Charleston. In 1919 he began the practice of medicine in Summerton and has had a large practice there since that time. Although he had been in poor health for some time he had continued to work up until his sudden passing.

Dr. Carrigan is survived by his widow and four brothers.

President's Page

(As his first official act, Dr. W. T. Brockman, newly installed President of the S. C. Medical Association, represented the Association at the testimonial dinner to Dr. Fred Williams on April 30th, and presented the following tribute.—Editor.)

Charles Frederick Williams — Citizen

My Friends and Fellow Physicians:

We honor ourselves on this occasion by honoring in a dignified and significant manner one of our outstanding physicians.

Within the medical profession it has been my great good fortune to know men of the highest ideals and culture, and in general, to find in the profession a great friendliness. Our common interests bind us together, and although we sometimes disagree, there is today, as there has been throughout the centuries, to use Osler's words, a "remarkable solidarity."

Among the great professions, the physician occupies a commanding place. For selfless and devoted service, for the highest expression of generosity and good will, the physician occupies a place quite incomparable. The story told by Ian Maclaren in the "Bonnie Brier Bush" of old Dr. McLeod is not exaggerated or overdrawn. It is a tale that may be duplicated in many communities. One must believe concerning men of this type that they are motivated by the highest of impulses.

I know of no finer group of professional men than those who compose The South Carolina Medical Society.

Friends — this program is dedicated to our beloved retiring Superintendent of The South Carolina State Hospital.

Gratitude is a noble virtue. But even the most grateful may overlook the fact that for so many of our present benefits we owe a debt of gratitude to those who have gone before and blazed the trail to the present for us.

Let us hold on most vigorously to the good things handed down to us. Let us not be quick in accepting the ultra new without first asking whether it discards the good principles which we have been fortunate enough to inherit.

If some debt collector should attempt to collect what we owe to those who lived before us, he would have on his hands a job that he never could finish.

Yes, somebody ought to put a sign high up in the sky where all doctors could read it: "Beware lest you forget your forefathers and their labors for you."

The business of the scientist is to *seek* for truth and having discovered it, *turn* it to practical account. It is summed up in the three words: *searching, finding, and applying*. The career of Doctor Williams parallels the true scientist, who can say: "I sought, I found, I applied."

This duty of expressing appreciation for valued services rendered awakens a two-fold emotion. First, there is the pleasure of having been selected for this particular part of the program; but then there comes a wistful reminder that in performing this duty, I am bidding good-bye to some of the activities of one of the most esteemed physicians of this State.

In every generation there are few men who, because of some outstanding attribute, such as philanthropic aims, or intellectual achievements or loyal service, have won the respect and love of their fellowmen. It is these men who raise the average of humanity—and by their words and deeds brighten the world about them.

Such a man is our distinguished citizen, Doctor Charles Frederick Williams. The story of his life is well known. We are familiar with his achievements, and we know how we have benefitted through his faithfulness. All of this has won for him the warm place which he will ever hold in our hearts. Our lives are richer and fuller because he lives. It is natural that we should desire to give some expression to our appreciation. We have therefore assembled here in his honor.

Dr. Williams, we have enjoyed the years of close association with you. We have respected your ability and honored your integrity. We want you to accept our esteem and good wishes. May the future bring you added honors and the opportunity to display the genius and ability which are yours in so large a measure.

When a man brings to an office great ability, keen judgment, intrepid honesty, and an ability to win friends, he should receive our wholehearted commendation. We feel that you, Doctor Williams, possess in the highest degree all these requirements.

It is superfluous to tell you in words how proud and happy we are to honor you. The presence of so many of our citizens and their smiling faces alone assure you of their hearty good will, and the pride we feel in having had such a distinguished co-worker as yourself.

There is one thing which is admired above all others and that is success. It does not so much matter along what branch of human endeavor a man's talents lie—whether art, literature, the professions or business — the fact that he succeeds, proves that in his particular field, he has greater ability than his fellow man.

Many people insist that success is largely due to luck, to circumstances, not realizing that it takes genius to shape circumstances to the proper end. It is true that "there is a tide in the affairs of men, which taken at its flood, leads on to fortune," but how many of us know the tide of our destiny is at its flood?



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Southern Dairies



Division of National Dairy Products Corporation

Our distinguished guest has met with a large measure of success, but the success is not due to luck. It is a substantial edifice founded on the solid rock of genius, integrity, loyalty, and earnest endeavor, coupled with a keen perception, which has enabled him to foresee opportunities and grasp them as they appeared.

Dr. Williams is a man trained in the discipline of medicine. All his life, he remained loyal to that discipline. But, especially in these later years, he has taken all knowledge for his province. He feels that all facts of nature have some bearing on the maladies — mental or physical, and he drew no hard lines between them. Medicine, to him, is not included between the leather covers of any compendium of medical practice.

Most of his life has been passed with sick of body and mind. Much of his time has been taken up with the routine of administration demanded of the member of civic organizations, service clubs and institutions.

But in the midst of it all, he somehow has found time not only for the formulation of his philosophy of medicine but for the education of many colleagues who will carry on the work he has fostered.

The physician's problem is to find out what is causing the trouble and set it right. Doctor Williams has long recognized this fact in the field of mental illness, so far as the individual is concerned.

Doctor Williams' great specialty has covered a broad field, and he has given aid to countless persons.

The inspiration of a living example has been an important factor in the building up and the maintaining of morale among all those with whom he has worked.

Again we realize the public spiritedness, the civic energy,—as embodied in the character of Doctor Williams—which has always been in the minds and hearts of doctors.

Doctor Williams' right to his testimonial program is attested in the record of his public life, and no

man, whatever may be his partisan faith, will undertake to deny him this recognition.

In life, he has achieved successes and gained a reputation beyond the reach of any man not endowed with the highest intellectual gifts and habituated to the practice of tireless energy. These qualities of character have secured for him the association and respect of the most prominent and influential men of this city and state—and advantage that gives to him a standing most valuable to the interests of the medical profession.

We have talked a good deal about the survival of the fittest. But who are the fittest to survive? The fleetest? "The race is not to the swift." The mightiest? "The battle is not to the strong."

The fittest to survive are not the fleetest, nor the strongest, but those who, impelled by altruistic motives, render the greatest service to their fellows.

Only those with understanding and sympathetic minds survive in the memory of their fellows. A life of service is to be preferred to any other kind of career.

When Doctor Williams leaves The South Carolina State Hospital, a place will be vacant that will be difficult to fill. His many friends here and all over this State will miss his companionship and his counsel, but they wish him every success in his future endeavors.

What a flood of happy recollections come tumbling down the stream of memory as we look back upon the friendships developed by years of association with Doctor Williams.

He has attained positions of higher honor in this community, and yet, his ambition has been to serve his fellowmen in a representative capacity. He has contributed to the sum total of knowledge and ability that is so necessary to our profession. To the younger members of our profession, his example of good citizenship, will be a source of inspiration, and to us all, he is united in the bonds of real friendship.

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AERA SAKOS

The writing a humorous column or the reading of one depends a great deal upon the writers or the readers frame of mind. It so happens that many of us are somewhat vicious in our attitudes toward our fellow-man, particularly toward those considered our superiors. To illustrate this point I think often of the sergeant and private who were before the Military Court for kicking a Colonel. The Sergeant explained that as he got out of the staff car, his knee struck the door and by a peculiar reflex action he kicked out and met the Gluteus Maximus of the Colonel. (An Maximus it usually is, on a Colonel). The sergeant was excused for his conduct and the private was asked to explain his action. He replied, "Well, as I came around the car I saw the sergeant kick the Colonel and knowing the war must be over I let him have one too!" Here is a private that really knew what he wanted to do and it seems a pity that he was a bit premature.

There is the type individual who always seems to be on the wrong end of things. One day a man was complaining to his friend that fate was against him, that he never got a break—that he always came out on the little end, etc., etc. His friend remarked that certainly it couldn't be that bad. "Oh yes it is," the first replied, and at that moment a bird came by and at high altitude bombing, hit as his target the top of the poor unfortunate's head. "You see!" he shouted "For other people, they sing!"

There are, of course other types. I like the meek group as typified by the little guy attending a lecture on Reforestation. The lecturer said: "I don't suppose that there is a person in the house who has done a single thing to conserve our timber resources." Finally the meek one's voice came through very timidly. "I once shot a woodpecker!" There's the opposite though who a bit drunk in a telephone booth was heard to shout, "Number hell, I want my peanuts!"

We know the penitent type also. A man had a broken arm which he said he received from fighting for a woman's honor. It seems that she wanted to keep it. The resigned type is illustrated by the following: A southern Negro upon receiving his draft questionnaire struggled desperately with the long list of questions. He looked it over for a long time, scratched his head and began to sweat profusely. Finally he gave up in despair and returning the blank questionnaire to the draft board, made this notation on the last page, "I'se redddy when you is."

We would like to close with a thought that appeals to us. "The trouble with our schools is that the teacher is scared of the principal, the principal is scared of the superintendent, the superintendent is scared of the school board, the school board is scared of the parents and the parents are scared of the pupils, and the pupils—the blessed pupils are not scared of anybody or anything!"

LEGISLATURE ADOPTS "BLUE CROSS" BILL

At long last, on Saturday, May 5, the last day of the session, the Senate concurred in the House amendments to the "Blue Cross" Bill and it became an Act. Thus was concluded the long fight which has been in progress continuously since the middle of January for the enactment of this constructive legislation.

As this is written, the act has not yet been signed by the Governor and this, of course, is necessary before it becomes effective as law. Final action by the Legislature having come when it did, it is not necessary for the Governor to act immediately. He has indicated, and we feel reasonably confident, that the act will be signed.

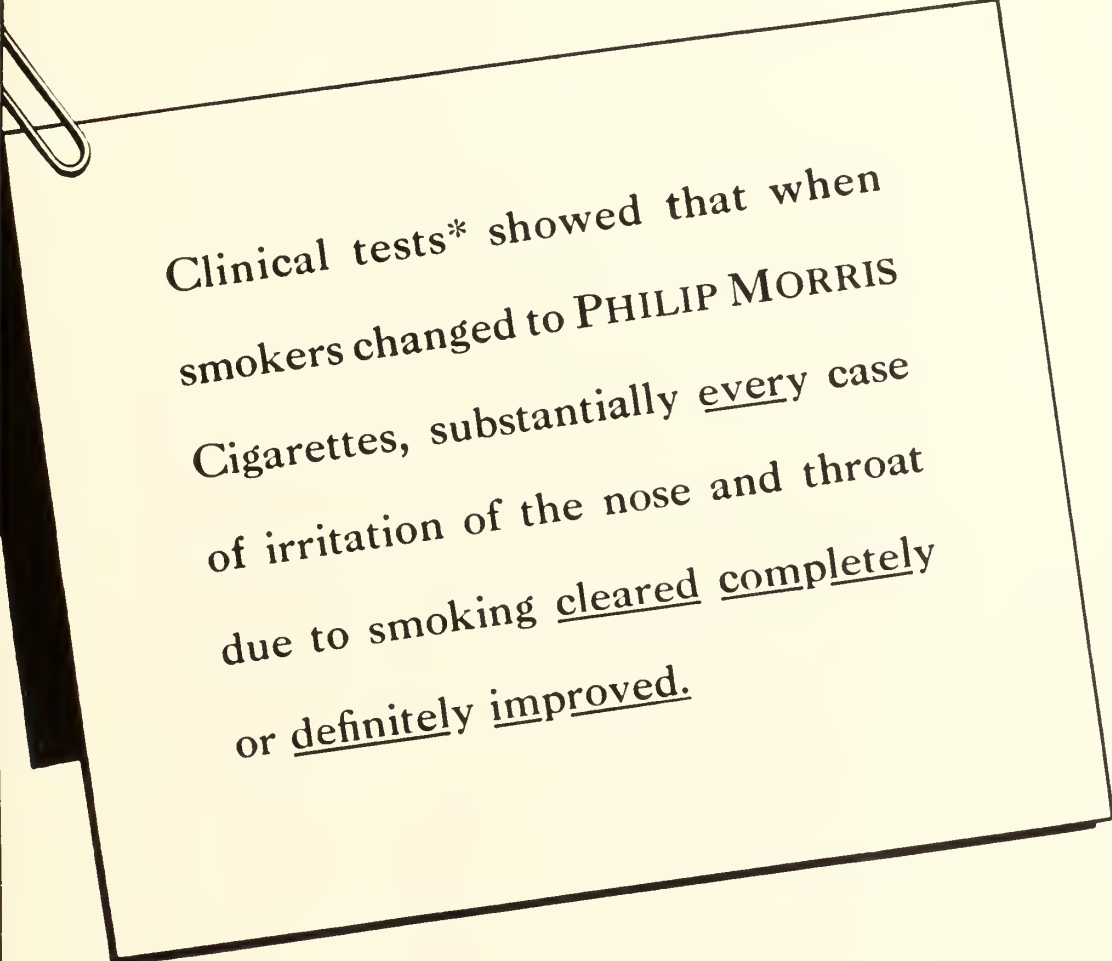
The majority of both the Senate and the House were always in favor of the Bill. The minority, however, were most determined and resorted to the only tactics at their command which could have served to defeat our purpose—the strategy of delay. It almost succeeded. In order to obtain passage of the Bill in the House, it was necessary to agree to certain amendments, thus making it necessary for the Bill to be returned to the Senate. It arrived there on Friday, May 4, and on motion of one of the Senators, was carried over to the following day and taken up on Saturday morning. There was an effort to send the Bill to free conference and, had this been done, there would have been no possibility of its being passed before the session adjourned. Senator Harvey of Beaufort County took an active interest in the matter and his vigorous effort is principally responsible for the successful conclusion by the vote of Senate concurrence the day the session ended.

The several amendments adopted by the House of Representatives, with two exceptions, dealt with the supervision by the State Insurance Department of corporations to be organized under the act. The objections raised by the opposition were generally to the effect that the Insurance Department, under the original Bill, had not sufficient authority. A reading of the Bill as originally introduced would serve to dispel any doubt along this line and these objections were primarily "smokescreen." The amendments, then, with the two exceptions referred to, restate in different language and somewhat in more detail the authority vested in the Insurance Department.

One of the exceptions is the provision inserted by the House for a reserve fund of 3% of gross annual collections from dues after the first year of operation. This is sound and salutary. A reserve of at least this amount would have been established without a statutory requirement. The other exception referred to is unfortunate and will cause some difficulty. This is the provision limiting the salary of any employee to \$4,000.00 per year. No doubt, this can be changed by amendment at some other legislative session. In the meantime, if the Governor signs the act, the organization of a "Blue Cross" plan in South Carolina can be set up and its operation commenced.

29 WORDS

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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2—149-154.*

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PUBLIC HEALTH NEWS

SENATE APPROVES \$50,000 APPROPRIATION FOR CANCER CONTROL

Money To Be Used For Hospital Care Of Indigent Patients

The Senate has approved a \$50,000 appropriation for hospital care of indigent cancer patients in South Carolina. Dr. Ben F. Wyman, State Health Officer, hails the measure as "one of the finest contributions ever made by the General Assembly to alleviate human suffering and misery." The money, Dr. Wyman said, is expected to be made available to the State Board of Health at the beginning of the fiscal year, July 1.

The appropriation will be used only for hospital care of indigent patients among South Carolina's 4000 or more cancer victims. It represents an increase of \$34,000 over last year's appropriation of \$16,000, and \$42,000 over the \$8000 appropriated year before last.

Dr. G. S. T. Peebles, Director of the Division of Cancer Control, has announced plans to resume the Cancer Control Program, which has been repeatedly interrupted and curtailed on account of a lack of funds, July 1. "This coming fiscal year," Dr. Peebles said, "will be the first year since the program was started in 1939 that sufficient money has been made available for hospital care of as much as one-third of the State's indigent cancer patients. Cancer," he said, "is the second greatest cause of death in South Carolina, exceeded only by heart and kidney diseases. The trend of cancer," Dr. Peebles said, "has been upward for the past ten years." There were 1205 reported deaths from cancer in South Carolina last year.

South Carolina's Cancer Control Program is carried on by the Division of Cancer Control of the State Board of Health. It operates under the Cancer Control Law passed by the General Assembly in 1939, providing for the diagnosis and treatment, at State expense, of indigent persons suffering from cancer, and for the carrying out of a plan for educating the public regarding the control of cancer.

The Division of Cancer Control, in cooperation with the staffs and superintendents of nine hospitals in various parts of the State, has established cancer clinics to which indigent cancer patients may be sent for diagnosis and treatment. The physicians who conduct these clinics give their services free of charge, and the State Board of Health reimburses the hospitals for the actual cost of caring for the patients.

Application for State-aid for his patient may be made by any physician in South Carolina. The financial condition of the patient is investigated by

the County Welfare Department of the county in which he resides. If the patient is determined medically needy, he is referred to the clinic he prefers to attend. Cancer clinics to which State-aid patients may be sent for diagnosis and treatment are held in the following hospitals: Anderson County Hospital, Anderson; Baptist Hospital and Columbia Hospital, both in Columbia; Greenville General Hospital, Greenville; McLeod Infirmary, Florence; Roper Hospital, Charleston; Spartanburg General Hospital, Spartanburg; Tri County Hospital, Orangeburg; St. Phillips Hospital, Rock Hill.

STATE BOARD OF HEALTH TO SUPPLY SERUM FOR PREVENTION OF MEASLES TO PRIVATE PHYSICIANS IN S. C.

A supply of immune serum globulin, a by-product from the blood donated by patriotic citizens, has been ordered from the American Red Cross by the State Board of Health and will be distributed free to private physicians in South Carolina for the prevention and modification of measles.

Dr. G. E. McDaniel, Director of the Division of Preventable Diseases, says the serum is expected in the next week and orders from private physicians will be accepted through local health departments.

Immune serum globulin is a substance separated from blood plasma to provide protection against measles. It can be used to prevent the disease or to modify an attack. It is being made available for the civilian population by the American Red Cross in keeping with its policy to return to the American people any useful blood derivatives accumulated in excess of military needs.

The serum globulin is being supplied without charge to state health departments for distribution to private physicians and hospitals, with the provision that it will be administered in accordance with established standards and without charge to the patient.

It will play an important part, Dr. McDaniel said, in helping South Carolina children to fight measles. It will prevent the disease, he said, if given within four days after exposure to a case in an infectious stage, and will modify the attack if given not later than nine days after exposure. A single dose will probably protect a child for about three weeks. If the child is re-exposed at the end of that time and protection is desired, the dose is repeated.

There were 40 deaths from measles in South Carolina last year, and 9,457 cases of the disease, including German measles, were reported.



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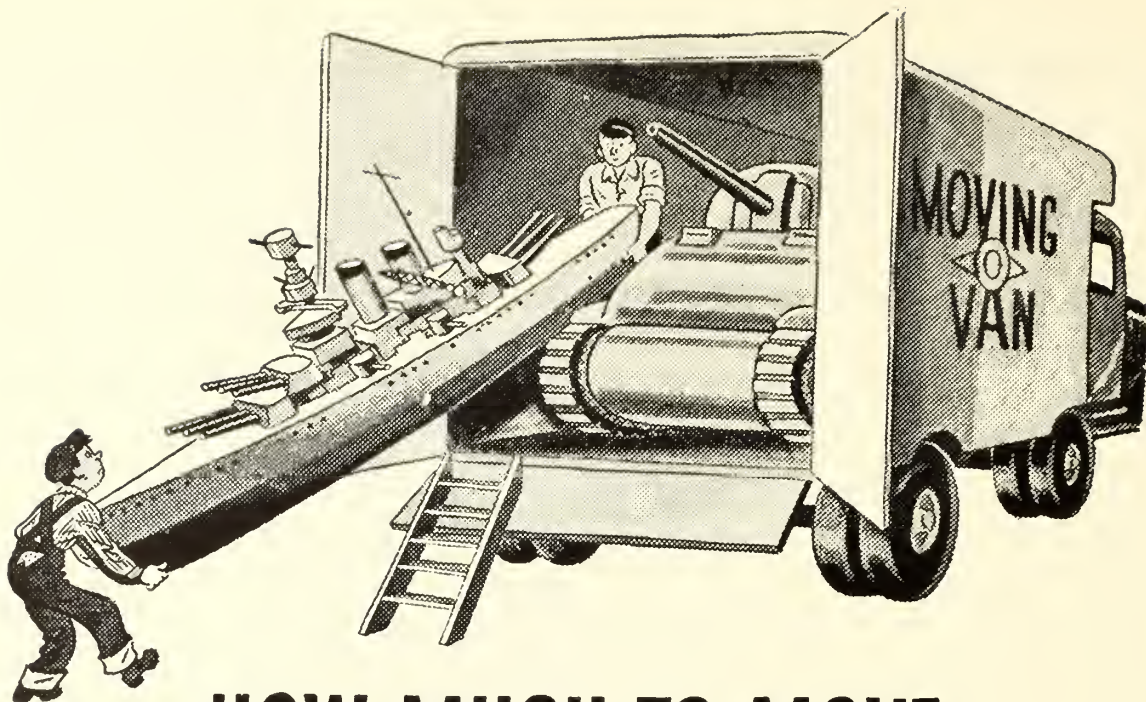
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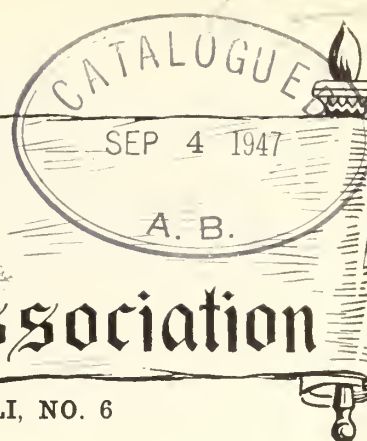


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225-250	150.00	200
210-225	131.25	175
200-210	112.50	150
180-200	93.75	125
140-180	75.00	100
100-140	37.50	50
Under \$100	18.75	25

ALL OUT FOR THE MIGHTY 7th WAR LOAN



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JUNE, 1945

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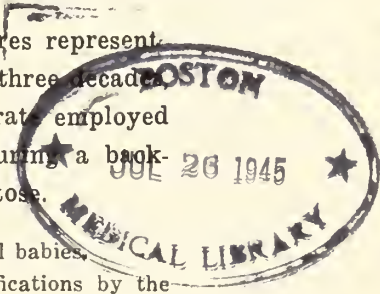
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BACKGROUND

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1. Am. J. Dis. Child. 54: 1227, 1937.



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of the

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VOLUME XLI

June, 1945

NUMBER 6

Hare Lip and Cleft Palate

A Plan of Management

WILLIAM H. PRIOLEAU, M.D., F.A. C.S., CHARLESTON, SOUTH CAROLINA

Infants handicapped by the developmental deformities of cleft of the lip and palate present various problems. The first is that of giving them nourishment, as there is an inability to suck and an interference with swallowing. By dropper and spoon feeding with the head inclined backward, the infant soon learns how to ingest his food and a good state of nutrition is maintained. Next in order is the stigma felt by the parents at having produced an infant of such horrible appearance. Certainly from this standpoint early correction is desirable. On account of the hideous spectacle they present, these deformed children are shunned by others. They become asocial and their personalities become dwarfed. In later life they find it difficult to obtain employment. As they approach the age of two years and try to talk, it becomes apparent that their speech is understood with difficulty and that it has a nasal quality. For the above reasons as well as for others it is important that these deformities be corrected.

These deformities are of an hereditary nature and can be transmitted through either line. They occur in various forms. The cleft of the lip may be complete or incomplete, and unilateral or bilateral. The palate cleft is in the midline, and may be complete or incomplete. Commonly cleft of the lip and palate are associated, in which case the alveolar ridge is also involved. There are other less common types of clefts in this region.

The methods of operative correction have undergone a gradual development, and now the procedures are more or less standardized. The lip is first repaired. To do this early is of tremendous psychological value to the child and the parents. Also it has a very beneficial effect upon narrowing the cleft of the palate. The lip repair is generally made within the first few weeks of life, as soon as the child is gaining weight. It is most important that it be free of respiratory and intestinal infections. Ether vapor is the anes-

thesia of choice. The head of the patient is lowered so as to prevent aspiration of blood and mucus. Throughout the operation the pharynx must be kept clean by suction and sponging. The flaps are carefully outlined and marked. The lip is mobilized on each side of the cleft by incising the mucosa in the buccal fornix from the molar region forward to the cleft, and freeing the soft tissues of the cheek up to the infra-orbital ridge. The alae nasi are then freed from the underlying bone sufficiently for their mobilization. Hemostasis is obtained by gauze pressure and adrenalin. The margins of the cleft are then pared and the flaps are formed. The wound edges are accurately approximated and held in place by suturing the various layers. The nares should be well formed and equal, the lip of sufficient length and thickness, and the vermilion border well aligned. A Logan clamp may be applied to immobilize the wound. The elbows should be splinted to keep the hands from the face. Nourishment is given by dropper or spoon—at first clear liquids and then a suitable formula. No dressing is applied. The wound is cleansed with cotton swabs and covered with a bland ointment. The sutures are removed on about the seventh day. Spoon feeding is continued for still another week.

The repair of the palate is generally made between the ages of 18 months and two years. This time is selected as it is before speech habits are well formed, also in most cases the tissues have developed sufficiently to permit of closure of the cleft. It is important that the general condition of the patient be good, and that he be free of respiratory infection. Again ether is the anesthesia of choice. Aspiration of blood and mucus is prevented by lowering the head and keeping the pharynx clean by suction and sponging.

The Langenbeck operation is the procedure most commonly used. An incision is made on either side

through the mucosa and the periosteum to the bone just above the gum line from a point near the anterior margin of the cleft extending posteriorly curving around the alveolar ridge. The muco-periosteal layer is separated from the palatal bone. The edges of the cleft are pared. The soft palate is then mobilized by severing its muscular attachments to the posterior margin of the palatal bone. Mobilization is continued until the flaps easily approximate in the midline. Sutures are then placed so that the edges are broadly approximated and everted. Several sutures are placed on the superior surface of the soft palate. The child is placed face downward until he reacts from the anesthesia. Elbow splints are applied. Infusions and transfusions are given as indicated. Feeding is by spoon—at first clear liquids and then very soft foods. Solid foods are not permitted for some weeks.

Even though the closure of the palate be complete, these children should have special instruction in speech. As pointed out by Dr. Dorrance,¹ in some cases a congenital antero-posterior shortness of the hard palate prevents the soft palate from approximating the posterior pharyngeal wall. For correction of this defect several ingenious operations have been

devised. The teeth in the region of the cleft are likely to be deformed, and dental work is often necessary.

In adults, the correction of lip and palate deformities presents a more difficult problem due to the firmer fixation of the tissues and the freer bleeding. While the results are not as satisfactory as in infants, operative correction is well worthwhile as it makes it possible for these unfortunates to obtain employment which their unsightly appearance had theretofore made impossible.

Remaining defects in a repaired lip may be corrected to a great extent, likewise in the palate. However in the latter, each successive operation is more difficult as the tissue is less in amount, and the scarring interferes with the blood supply. Dental obturators may satisfactorily occlude small openings in the anterior portion of the cleft.

Operations for correction of cleft deformities of the lip and palate are associated with a definite risk and mortality. Maintaining an unobstructed breathing passage is difficult. Careful attention to detail is necessary to prevent serious complications and even fatalities.

1. Dorrance, G., & Bransfield, J. *Ann. Surg.* 117:1, Jan., 1943.

Colored woman, aged 31 years.



Fig. 1.—Bilateral cleft of lip and alveolar ridge. Complete cleft of palate.

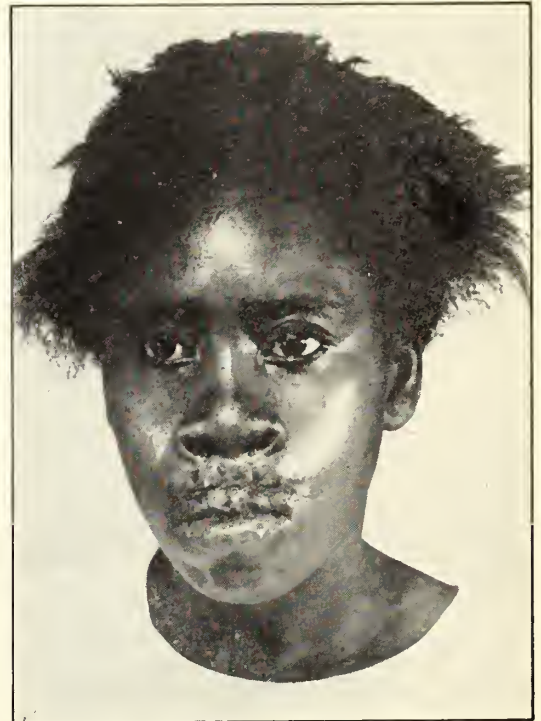


Fig. 2.—Ten days after operative repair of lip.

Recovery From Streptococcus Viridans Bacteriemia-Case Report

GEO. D. JOHNSON, M.D., SPARTANBURG, S. C.

M. G. M. a four months old white female was admitted to the Spartanburg General Hospital 7-6-44.

C. C. High fever, vomiting, diarrhea, crying constantly.

F. H. Father 24, Mother 23. Both in good health. Father in the Navy. One older sister 2 years old. No known tuberculosis, hay fever, or asthma on either side of the family.

P. H. Baby weighed about 6 lbs. at birth. Normal, easy delivery. Hare-lip present at birth. No cyanosis or difficulty in instituting respiration. On June 21st baby had repair of hare-lip in Greenville, S. C. The sutures were still in the lip and alveolar ridge and the Mother attributed the crying to these sutures.

P. I. Baby has been ill nine days. Infant was treated at home by sulfonamides, but without noticeable improvement. There has been fever, vomiting, diarrhea and very little sleep. Infant seems uncomfortable most of the time.

P. E. 7-6-44. Small, but fairly well developed and nourished female infant. Weight 13 lbs. Anxious expression. Cries constantly, abdomen soft, no mass or tenderness, liver normal in size, spleen not felt. Lungs clear throughout. Heart very rapid, but regular in force, rate, and rhythm. No murmurs heard. Ears normal. Mouth: Sutures in upperlip inside surface and in alveolar ridge. Throat: Tonsils small-pharynx and tonsils only slightly injected. No Brudzinski or Kernig, fontanel not bulging. Skin: Marked dehydration even of deep subcutaneous tissues. Scattered petechiae over abdomen, arms, and legs. Slightly cyanotic hue to skin especially of lips.

Imp. 1—Convalescent hare-lip repair.

2 Improper diet.

Course. 7-7-44. Patient was started on skimmed milk and Casec, sulfathiazole grs. II 4 hours. Temp. 104°. Patient's respiration became so weak that artificial respiration was employed at one time and Coramine given. 500 cc Hartman's solution given intravenously slowly over a period of four hours. Temp. had dropped to 97°, now back to 104°. Sheet packs used repeatedly. Clysis that night of 200 cc Hartman's solution given. Sutures in lip and alveolar ridge removed with approval of the surgeon.

7-8-44. Temperature varies between 104° and 102°. Baby had an intravenous of 10% glucose in normal saline—150 cc and a clysis of 200 cc Hartman's solution. Took formula fairly well. Sulfathiazole discontinued at 6:00 P. M. Blood Count: Hbg. 63%; R. B. C. 3,650,000; W. B. C. 12,250; Youngs 2, Segmented 48; Lymphocytes 50.

7-9-44. Temperature between 103° and 101°. Sulfadiazine grs. II given every 4 hours. Dr. Boyd saw patient and suggested the possibility of pneumococcal

blood stream infection. Transfusion: 100 cc citrated blood given without reaction.

7-10-44. Temperature between 103° and 101°. X-ray chest normal. Urinalysis normal. Only two stools in 24 hours. Baby eats fairly well.

7-11-44. Temperature same. Thrush in mouth. Blood culture showed a staphylococcus, probably contaminant.

7-12-44 to 7-15-44. Temperature varied between 101° and 103°. Infant ate only fairly well. Bowels about the same. On the 15th a clysis was given because of dehydration again. Penicillin, 5,000 units intramuscularly every 4 hours started.

7-15-44 to 7-18-44. Temperature generally lower. Another blood culture showed a staphylococcus. Penicillin increased to 10,000 units every 4 hours on 7-18-44.

7-19-44 to 7-24-44. Temperature below 101°, usually below 100. Marked drop after penicillin was increased. 7-22-44. Streptococcus viridans isolated by blood culture. Blood obtained 7-19-44. All petechiae have disappeared. Sulfadiazine stopped 7-24-44.

7-25-44 to 7-29-44. Temperature up to 102° every day with gradual lessening of height of temperature curve. The baby had developed an abscess at the site of injection of penicillin. The nurses had given every injection in one of the two buttocks. The abscess subsided. Penicillin discontinued.

7-26-44. Temperature normal after 7-29-44. Baby discharged 8-3-44. Blood count on 8-2-44. Hbg. 73%, R. B. C. 3,750,000; W. B. C. 6,700; Youngs 2; Segmented 58; Lymphocytes 40.

When discharged patient was eating well, smiling and gaining weight, lip had healed entirely. To-date (3-19-45) patient has remained free of further blood stream infection. She has been in the hospital four or five times but for mild respiratory infections of short duration only.

Comment: So far as could be determined this patient acquired a streptococcus viridans bacteriemia from the repaired hare-lip. No other focus could be found. The ears were always normal. Except for easily controlled thrush, the mouth and throat were never seriously infected. The lungs and heart were normal. Sulfathiazole and sulfadiazine in fairly large (gr. I per lb. per day) dosage were of no avail. Penicillin produced prompt clinical improvement and when the dosage was increased rapid subsidence of fever. In retrospect it would have been better to have given 10,000 units of penicillin every three or even every 2 hours.

Summary. A case of streptococcus viridans bacteriemia is reported. Its cure was apparently effected by penicillin and the removal of the source of the infection.

Pregnancy Spacing in South Carolina From the Public Health Standpoint

JOHN B. NETTLES, CHARLESTON, S. C.

Concluded from April issue

PART II

Acceptability of the Program

From approximately 2000 cases in Berkeley, Lee, and Kershaw counties it has been found that fully 80% of the patients accepted the theory and practice of pregnancy spacing insofar as they were able to do so. If given a simple method free of nuisance value less than 20% of the patients will have to be dropped from the "active" list, as long as their interest is kept alive and stimulated. If active attempts are made to keep these patients interested and supplied with materials the value of the program will be increased. It has been found that 95% of the patients classed as prospects appeared sufficiently interested in contraception to be supplied after preliminary instruction in the method. After being supplied each patient should be furnished with a postal card with which she can request refills of the material before her supply is exhausted. This makes the continuation of the method more acceptable in those cases in which it is not convenient for the patient to "drop by" the health office.

No single objection has been reported that is pertinent; but a combination of stupidity, lack of interest in any form of self-help, unsettled sex life and superstition predominate. Contraception may be "against nature" or "against God's will" or they may say "my man think me too weak if I can't have a baby." Around 20% of the public health patients are of such character—much like one darkey who came to an obstetrical clinic who replied, when asked as to the father of her child, "Well, Doc, when a buzz-saw cut you you don't know which tooth bit you." Normally we can expect 20% loss in any public health program because of such patients. Only 16% were lost in the pregnancy spacing programs in Lee and Kershaw counties among 965 cases.

Effectiveness of the Program

Public health demonstrations were carried out in three counties, Berkeley, Lee and Kershaw. Berkeley is a rural county of 27,000 population, 70% negro. About 85% of the women are attended by midwives and most receive their prenatal care from the county health department. Most of the inhabitants are tenant farmers with an average cash income of less than \$100.00 per year per family. Many live five miles from a paved road, in semi-swamp-land, in homes inaccessible during the rainy season. Illiteracy is prevalent. There are few radios and almost no newspapers or magazines. Almost all receive benefits from the public health units but cooperate poorly in all its programs. Many of them believe that treatment of disease is against "nature." In 70% of the prenatal patients the hemoglobin is below 70%

(Dare). About 90% of the indications for contraception were multiple pregnancies at close intervals, four or more at an average of 10 months apart. Even under these conditions a pregnancy spacing program was fitted into the public health set-up. Results have been encouraging.

Lee County is much like Berkeley in respect to population, proportion of negroes, annual birth rate and economic level, but has a better intelligence level of the negroes and better transportation. Lee more nearly represents the average rural county in the South Atlantic Area. Here, out of a group of 218 active cases, only four pregnancies occurred when the method was properly used. The 1941-42 survey showed that a graduate nurse with no special training other than detailed instruction as to the use of the materials and the method of keeping a check on the patients can keep about 50 active cases on her roster, and she can do this effectively. She, of course, works under the supervision of a physician. In this county during the twelve month survey the reduction in fertility was 78.5%.

A third survey was carried out in Kershaw County which is quite similar to Lee except for the slightly more urban influence contributed by its county seat, Camden, a winter resort. The county health department was able to carry out the program with the addition of a nurse and a clerk to its personnel. The reduction in fertility here as a result of the program was 84%.

The following table shows in detail the effectiveness in Lee and Kershaw counties. This is a recent (1944) report.

Effectiveness of Materials

The measure of the effectiveness of any contraceptive is based on two considerations:

First: The willingness of the patient to use it regularly.

Second: Its value in preventing pregnancy.

Therefore the measure of the effectiveness of the material can be derived only by studying those who become pregnant in spite of regular use. Among 553 patients on various methods there was an effectiveness in reduction of fertility of 93.6%. Such a result can only be classed as extraordinarily satisfactory, and is a higher rate of success than has been obtained in the rest of the public health program. No significant differences have been noted in the effectiveness of the several materials used in the program.

When we take into consideration the mental capacity of these public health patients as compared with urban white clinics or private practice the 93.6% reduction in fertility is about as near 100% as could be hoped for. We may also note that the several materials can be prescribed to patients of a

higher mental level in the confident expectation that the pregnancy preventive value will be over 99%.

Analysis of Pregnancies

In 965 cases studied in Lee and Kershaw Counties 238 pregnancies occurred. In only 42 (17.6%) was method failure responsible. In a survey by the Charleston (Maternal Welfare Bureau, Inc.) Clinic for Charleston County for the twelve months ending July 1st, 1943, it was found that in 788 cases studied 166 pregnancies occurred, but only eight were due to method failure. In another Charleston survey 17 pregnancies occurred among 200 patients.

Results of the Program

In S. C. for the year 1936-1937, about 25% of the maternal deaths were among those in whom a physician had diagnosed chronic disease and had recommended no further pregnancies. Following the statewide application of pregnancy spacing to the problem, we find that during the fiscal year 1941-1942 that less than 10% of the deaths were among the chronically unfit for pregnancy. This reduction was large enough to be significant and reflects the benefits of the program now in effect.

A statewide survey of the program in the counties revealed wide differences in effectiveness, as occur in all other programs. Those areas with the greatest need for public health services present such a wide variety of problems that the county health officer is often torn between his ambition to give the patients the individual care that they require at the expense of large numbers treated, and the natural response to the needs of the multitude. Conditions demanding care always exceed his supply of personnel and time and in consequence his program is chiefly one of "clinics" — and often his clinics are so overcrowded that intelligent and definitive treatment is inadequate. The net result is that he is inclined to stress the care of those conditions in which he is especially interested and which receive the greatest support from the physician serving his clinics, and to give less active attention to the other conditions.

The value of the program rests not solely on the activities of a given clinic in a county, but perhaps even more important, in the bringing to the attention of the profession at large the necessity for it and to the means which may be employed to accomplish this purpose.

Depending as it does on strict individualization of the patient and a physician's prescription in each case, one of the aims of this program is to make pregnancy spacing as ethical as any other health work.

It is interesting to note that 20% of those patients offered a birth control method, after instruction, refused to use it, being of that hopeless, uncooperative type always to be found in public health clinics. Also it is interesting that these patients are distributed over less than half the counties. Such results are sufficiently encouraging to

warrant the continued development of pregnancy spacing activities.

One of the most valuable results of this program has been the regulation of the dissemination of contraceptive advice. When the program was put into operation it was found that government organizations (of lay membership without medical supervision) had field workers in this state who were giving out contraceptive material without any record of medical indications for it and in some cases to those obviously able to pay for it. This was unfair, both to the physician and the druggist, and was a form of medical practice by a non-licensed non-medical group. When this was brought to the attention of the central office in Columbia and the plan of the Maternal Welfare committee submitted, cooperation was promptly secured. Under the present plan any woman who, in the opinion of the field worker, should have contraceptive advice is referred to the county health officer for investigation, and if it is proper she receives it, and if not, the reason for this is communicated to the field worker. So far this plan has worked admirably with the minimum of friction and no contraceptive advice or material is given to patients without prescription, through field worker or other personnel, and this is in marked contrast to the conditions in other states. Any physician can write the prescription for contraception through the public health. Other agencies, especially welfare groups, have been reached and the service explained to them with gratifying results, again depending upon the influence of the county health officer and the cooperation of the local medical profession.

This pregnancy spacing project has been fitted into the general health program with a most pleasing record of wide service. It has always been run in conjunction with the other programs of the public health. One of the results of this is that a better study has been made of anemia and dietary deficiency and prenatal care has been improved. Incorporated into the program besides instruction in contraception and supplying of materials and supplies have been adult conferences, group talks and some sterilizations through a special fund.

This program has been carried out at a cost of \$7.50 per patient per year, approximately the same as the cost of venereal disease treatment. The material contributed gratis by manufacturers has balanced special clerical services required in making records and analyses in surveys.

The Charleston clinic found that some of the husbands objected to the odor of the jelly (orthogynol) and suggest that this be removed by the manufacturer. Some complained that the jelly caused too much lubrication. The type jelly or the amount used could probably alter this situation. Several patients objected to the excretion of the material the next morning, but prefer this discomfort to the risk of becoming pregnant. Only a small group have facilities to take a douche.

The use of the diaphragm has been limited in all clinics, but has been used more extensively in the Charleston clinic than in the state public health clinics. A higher intelligence level is required for the diaphragm than is possessed by most of the patients.

This program has pointed out the importance of

cooperation in the public health program. Cooperating with the state and county units have been the American Birth Control Federation of America, Inc., the Maternal Welfare Bureau of Charleston, Inc., and the state and local medical societies, the pharmaceutical manufacturers, individual physicians, nurses, midwives and patients. Strange to say, of

Acceptability and Effectiveness of the Program

County	Kershaw	Lee	Combined
Total patients in program	518	447	965
Moved out of county	105	41	146
Number remaining	413	406	819
A. Active	247	180	427
B. Inactive, pregnant	91	147	238
C. Closed	75	79	154
a. Failure of program			
1. Mentally deficient	6	2	8
2. Husband objects	9	14	23
3. Patient not interested	58	46	104
b. Service unnecessary			
1. Husband died	0	5	5
2. Husband away	0	8	8
3. Menopause or hysterectomy	0	4	4
4. Pregnancy desired	2	0	2
Preclinic pregnancy rate	105.	116.	112.
Post clinic pregnancy rate	31.3	21.8	26.8
Reduction in fertility (as result of program)	70.2%	81.2%	75.9%
Acceptance rate	91.7%	83.4%	

Below is tabulated an analysis of the pregnancies from two surveys in each of three counties. In all these surveys jelly, creme or foam-powder, or a combination of these, was used. This table is self-explanatory, but it may be pointed out that of the 2608 pregnancies 91 or 3.1% were voluntary pregnancies.

Method failure from apparently unpreventable causes occurred in 54 or only 2% of the cases or 10.8% of the total pregnancies. Failure to use the method *regularly* resulted in 62% of the pregnancies. At times this was due to the failure to replenish supplies.

To be classed as method failure the patient must have had at least two periods following the use of the method to be sure that she was not pregnant at the time she began it, and be able to describe the method without prompting to a field worker and that she assure the worker that the technique was followed and that the worker found that sufficient material had been used to suggest that her statements were true. The majority of those who became

pregnant apparently were victims of irregular use and this is the greatest single cause for the failure of contraceptive methods. It is difficult to convince any patient that there is no "safe period" when a contraceptive is unnecessary; and it is even more difficult, when this conviction is reached, to have her "take the trouble" to make the necessary preparations. To a certain extent this represents failure both of the patient and the field worker. It is well known that the nurses who are more convincing in their instruction have a lower casualty rate.

Those who have a delayed period and believe themselves pregnant are most difficult to keep in line. The majority of women whose periods have been reasonably regular are convinced that they are pregnant when they are some five to seven days late, and without further ado abandon the method prescribed. This is a human factor and not a fault of the method or material. The state public health survey showed that the simple materials and methods they used were 83% effective in preventing pregnancy among those who used it regularly.

Table: Analysis of Pregnancies

County	Cases	Pregnancy Desired or Method Abandoned	Incorrect Use of Method	Failure to Use Method Regularly	Method Failure	Total
Lee (1st survey)	335	9	2	3	4	18
Lee (2nd survey)	518	0	2	68	21	91
Kershaw (1st)	320	4	2	14	0	20
Kershaw (2nd)	447	0	4	122	21	147
Charleston (1)	200	22	20	17	0	59
Charleston (2)	788	56	13	89	8	166
TOTAL	2608	91	43	313	54	501

this group, the least amount of cooperation has been given by the patients for whom the program has been set up, and over 80% of them are cooperative.

The senior students at the Medical College of the State of South Carolina are given an opportunity to get practical instruction and experience in the Charleston clinic.

Summary

1. An extensive pregnancy spacing program has been well integrated into the public health program in South Carolina. At the time of the initiation of the program 25% of the maternal mortality was among those chronically unfit for pregnancy before the final began. This has now been reduced to 10%. In addition the maternal morbidity has been reduced.

2. Various methods of contraception have been used. Due to the low intelligence of the average public health patient the simpler and inexpensive methods have been found best. The jelly-alone and the foam powder methods have been found satisfactory, but special efforts must still be put forth to maintain the patients' cooperation and to see that they understand the method. When properly used these simple methods are very satisfactory.

3. The state health unit plan in no way competes with the physicians or druggists since all public health patients must be unable to pay for services before they are given them by the health unit.

4. Under medical supervision laymen may be of great help in the public health program.

5. Well over half of the patients who became pregnant while "active" did so because of failure to use the material adequately. Relatively few became pregnant because of method failure.

6. This program has done much toward keeping the dissemination of contraceptive information under medical supervision.

7. Training in contraception is offered the future practitioner through the Charleston clinic and the

Medical College of the State of S. C.

8. In those localities in which all groups cooperated well results have been excellent; elsewhere they need to be improved.

9. The reduction in fertility is the overall reduction and not the reduction in any given case.

10. Special effort must be made to improve the program in those few counties where cooperation has not been excellent.

11. The program is well started and is now on a firm basis, but the need of the program will always be great. The program must always be actively pushed.

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"FOR MERITORIOUS SERVICE AND DEVOTION TO DUTY"

One evening recently five physicians met in the York County Hospital for a staff meeting. As they sat and chatted, someone suggested that they determine the number of years of practice they had given to South Carolina. Each of them had spent his medical life in this state and as they added the figures they found that the five of them combined to make a total of 240 years. Five men have practiced medicine in South Carolina for a total of 240 years—and each of these five is still at work. We claim this as a record unparalleled in any county of similar population (58,000) in the United States, and we are proud to honor them and to claim them as our colleagues.

These five physicians and the number of years which they have served are **Dr. Joseph H. Saye** of Sharon, 62 years; **Dr. William A. Hood** of Hickory Grove, 56 years; **Dr. Charles B. Harrell** of Rock Hill, 47 years; **Dr. James R. DesPortes** of Fort Mill, 45 years; **Dr. James B. Elliott** of Fort Mill, 40 years.

(If any civilians are to be awarded citations or medals of honor, we present these five physicians as our candidates for such distinction.)

The Journal of the South Carolina Medical Association

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WHAT THEY ARE THINKING

As our colleagues in uniform go hither and yon in this country and overseas, they cannot but think of the "folks back home." But what are they thinking? This, your Secretary has attempted to discover through letters.

From the Philippines comes a reply which we pass on to each member of the Association for careful reading. At the request of the writer, his name is withheld.

"I have carried your letter of November 22nd. from the States over most of the S. W. Pacific, as I flew out from Pearl Harbor, because I enjoyed it and wanted to reply.

"Many of your questions could be answered in the same way you would answer them there. You mention hospital insurance and some form of sickness insurance. With this, I personally, and most of us, are heartily in favor. We feel that this is the best method of giving the best medical care to the class which needs it. It is felt that these millions of men are accustomed to being treated thoroughly with all needed facilities, and that they will demand at least this when they return. And they will want it without undue financial sacrifice. (This war has been as big a dream of many enlisted men financially as it has been to no medical officer.)

One of the sad parts of this business is that we do not feel that we are really missed by all our colleagues back home. True or not, the general feeling is that doctors there aren't working as many hours a day as many of us are, here in the forward areas. And that the increased demand for medical care has been pretty well capitalized on. Conversely we hope that you have trained patients to be more considerate in their demands, and that we may share this benefit with you later.

"Tho' we feel that there have been many men accepted as medical officers, who have much more reason to have stayed home than some who hid behind technicalities to stay put, still hardly a one of us would come home voluntarily until we see this thing through.

"Our most acute discomfort is loneliness for our

families, and sorrow that we miss years of happiness being away from them. I think we are all resolved that when we return we will spend every available moment with them and will not expend all our energies on practice as before. We are anxious to get back and hope we will be really welcome among our fellow doctors, for we have missed our contacts with you very much."

PAR WRITING

Nothing stirs the heart and stimulates the envy of a "dub" golfer more than to watch a master player who with consummate grace and apparent ease shoots the course in less than par. He studies the master as he tees off on the eighth hole—that short hole surrounded with traps. He smiles as the master hits the ball into the deep trap on the right—how often he has done the same thing with disastrous results to his score. But his smile of satisfaction turns to a look of wonder as the master, with cool nonchalance, makes his explosion shot and drops the ball within inches of the cup. He sees him do it and he tries to console himself with the thought that it was an accident, but he knows it wasn't.

What is true in the game of golf is also true in the game of writing. The dub looks at the master's work with admiration and envy.

There recently came to our desk a small publication; The Rockefeller Foundation, a Review for 1944, by Raymond B. Fosdick, President of the Foundation. Reviews of this type come to an editor's desk with frequency and are usually laid aside for casual perusal or for reference. And such was the case in this instance.

Several days later, we picked up the booklet in a moment of leisure and glanced through the pages. What began as casual perusal became intensive reading. Here was a word-master at work. Thoughts which we had tried to express in a paragraph or two were focused in sharp relief in a single sentence. Ideas with which we had toyed and for which we had tried to find words for expression were here presented with clarity and brevity. Pars and birdies in the game of writing were found at the very same

parts of the course in which we had finally scored sixes and sevens after arduous effort.

For those who, like the editor, enjoy the stimulating pleasure of reading writing at its best, we suggest they secure a copy of this little booklet. As a sample of the gems which are to be found therein, we give the following:

"A freedom-thirsty world cannot be kept permanently in chains. . . Men who have tasted liberty never forget the taste—nor their children after them.

"In the last analysis, not injustice, not Napoleon, not Hitler, but reason and truth are the conquerors of the world.

"The incalculable effects of freedom of thought are what totalitarianism fears most.

"The future, and the past as well, belong not to the Caesars or the Hitlers of the Hirohitos, but to those who dare to be free—The Galileos, the Wyckliffes, the Giordan Brunos and their spiritual descendants of today who in the agony of these recent years have stood for the truth.

" . . . scientists everywhere speak the same great language of ideas—an international language of tolerance and hospitality for those who choose to hear.

"In their intellectual life as well as in their physical life, nations and groups are becoming part of a vast living body.

"Thought cannot be confined behind boundary lines without loss of vitality and ultimate decay. No permanent walls can be built against ideas.

"At a time when propaganda obscures reality, and partisanship has a tendency to override the common interest, it is especially important for society to strengthen the efforts of those who can handle evidence with competence and integrity.

"We can look forward to no mechanistic invention which will automatically solve the problems of human adjustment. The coming peace will not be won or lost at a conference here or by a treaty there. We will be winning or losing it over the years ahead through many decisions taken by thousands of men in all the countries of the world. The peace is something we are ever winning or losing—today, tomorrow, next week, next year. We do not prepare for the decisions we have to make by putting on the blinders of intolerance and partisan advocacy. We shall be prepared only because, through education and study and research, we have developed leaders and citizens whose minds and integrity will be ready as the moments of decision arrive."

IN GOOD COMPANY

The Constitution and By-laws of the various state medical associations are very similar. There may be minor differences here and there but in the main the regulations which govern the activities of the organization are identical.

It is of interest, therefore, to see how each association interprets its own laws. This is particularly

true at the present time when a war emergency exists—an emergency which was not foreseen when the various rules and regulations were adopted.

Our Council felt that the best interests of the Association could be served by elevating the President-Elect to the office of President—and this was done at the annual meeting of Council in April. Council studied the Constitution with care and concluded that it was well within its rights in so doing.

Within the past few weeks we have noted that the state medical societies of New York, North Carolina, and Missouri have adopted the same plan—they elevated the President-Elect to President, but left all other officers in status quo until the next official meeting of the House of Delegates. At least we have company, and good company at that, in what we did.

A SUGGESTION TO COUNTY SECRETARIES

No one knows better than we do the difficulty which is experienced by county medical society secretaries in securing papers and talks for the monthly meeting. To these gentlemen we pass on a recent experience in one of the societies as a suggestion.

To one of the members of the society came a new book: (Penicillin and other Antibiotic Agents, by Wallace E. Harrell.)

Since penicillin is a subject which is very much in the forefront at the time, another member of the society was asked to read the book thoroughly and to give a short summary of what he learned that was of interest to the practitioner. This was done—and the result was highly satisfactory. The reader of the book was greatly benefited, as were those in the audience who listened to his discussion.

Such a plan will enable a society to make use of certain of its members as speakers who do not or will not prepare an original paper. It is not a new plan by any means but so far as we know this society is the only one which has tried such a plan in recent years.

OUR ADVERTISERS

Once again we wish to call the attention of our readers to the advertisements which appear regularly in this Journal. These are not printed to fill up otherwise blank pages—they are communications from ethical corporations to individual physicians. Since the money paid for these advertisements helps to make possible the publication of this Journal, courtesy alone would suggest that the members of the Association read these messages from the advertisers.

THIRTY-FIVE YEARS

An occasion long to be remembered by those in attendance was the testimonial reception and dinner given in honor of Dr. Fred Williams upon his retirement after thirty years as Superintendent of the

South Carolina State Hospital. Leaders in medical, civic, and political circles gathered to pay tribute to this man who worked so long and diligently for the mentally sick of his state.

Under the leadership of Dr. Coyt Ham, newly installed Superintendent, a delightful program was arranged which began with a reception in the Mills Building at six p. m. (May 1, 1945). This was followed by a picnic style dinner served on the spacious lawn of the institution. The crowd then adjourned to the auditorium of the Administration Building where the "speechifying" took place.

Tributes were paid by James Adam Hayne, retired State Health Officer; Carrol H. Jones, prominent business man of Columbia and great friend of Dr. Williams; W. Thomas Brockman, President of the South Carolina Medical Association; Wm. R. Barron, Past-President of the Columbia Medical Society; and Samuel W. Hamilton of Washington, President-Elect of the American Psychiatric Association. Dr. Barron presented Dr. Williams with a gift from the Columbia Society. H. T. Patterson, Treasurer of the State Hospital, served as spokesman for the staff and workers in the institution and announced that sufficient funds has been raised from the personnel of the hospital to provide for an oil painting of Dr. Fred Williams by a noted artist.

Space forbids the printing of the various tributes which were rendered upon that occasion. For the sake of Dr. Williams friends in the state and in the armed forces—and these are legion—we have selected the one which was presented by Dr. Hamilton, for publication. Coming as it does from one of the leading psychiatrists of the country, it shows to what extent the work of Dr. Williams has obtained recognition beyond the borders of his native state—and for this every member of the South Carolina Medical Association, of which Dr. Williams is a Past-President, can be justly proud.

Dr. C. F. Williams and the American Psychiatric Association

One of the finest and ablest men in American psychiatry was Thomas W. Salmon. A few years ago—it seems only a few—he told me about some encouraging developments in South Carolina. The State Hospital was approaching the end of a century of very honorable history. Recently it had purchased a new site which must be developed, and the passage of time was forcing the selection of a new superintendent. The Governor was interested in progress and wished the National Committee for Mental Hygiene to study the situation. The Governor decided that for the work ahead he could trust one physician more than any other he knew, was getting him to undertake the superintendency, and would back him in strengthening the hospital organization and in developing greater service to the mentally ill of South Carolina.

It seemed that Dr. Williams was well fitted to run

a hospital. He had served two years in the United States Army, which gives to one with an organizing mind a very good foundation of orderly procedure. He had also headed the State Health Department, thus adding to his natural tact and friendliness a broader knowledge of the resources and needs of his native State than he might otherwise have had. Thus Dr. Salmon and Dr. Williams became friends. Dr. Salmon's friends were likely to be earnest and capable people.

Before long the rest of us began to meet Dr. Williams when he came to the National Committee for Mental Hygiene and to the conventions of the American Psychiatric Association. As befitted a gentleman from Columbia, he was a man of culture and his work and his social life were ably seconded by his family. More than that, he was evidently a good observer, logical in his application of the experience of others to the improvement of his own hospital, and a man of decision.

It happens that the president of the American Psychiatric Association lives on the Pacific Coast and cannot be here today, so I have the honor of representing that organization. It is the oldest National medical society and has a membership of some 3,300. It is therefore a body of size, of influence (we believe) and of dignity. In behalf of the American Psychiatric Association I congratulate all those who are joining in this celebration, and bring them the best wishes of the Association. We honor you and your ancestors for what South Carolina has done for the mentally ill of your State. We admire the standards that you have expected of the hospital superintendents who have served you. We hope for those to whom you entrust your hospital in future years a career of continued service on a high level and from time to time an expansion of organization that will be quite adequate to meet the needs of the patients within the walls and too of other patients in community whose lot would be grave unless the Commonwealth places diagnostic and treatment facilities in their path.

The number of mentally ill patients who at some time in their career have required hospitalization is very large. At present their number in this country is about half a million. Individual institutions have grown to the size of several thousand beds. Where so many human beings are involved, the problem of looking after them is not only a large problem but also a complicated problem. For instance, they must be fed. In order to give them good food and at the same time to employ helpfully a considerable number of patients, our hospitals are likely to have large farms. The farms must be well run and well stocked. At the same time we must use all suitable diagnostic instruments to determine to what our patients' symptoms are due. The electroencephalograph is a machine that measures the so-called brain waves, and tells us much about things like epilepsy and brain tumors. Appropriations even though liberal may never be large enough to get at one time all the things that the

hospital needs. Suppose in the same year there is need of a new young bull to raise the milk production and also there is need of an electroencephalograph, which to get the money for is a question not to be settled by a tyro. Again suppose that old people among the hospital patients are increasing in number; some day we notice that a considerable number of them never get out of doors because they live on the second or third story of a good old building that can give us service for several decades to come. Suppose that the surgical service and the operating room are on the ground floor of this building. Evidently the old people should be moved to the first floor. But what about abandoning the expensive operating room? And so a superintendent's life is taken up from day to day in making decisions that sometimes seem to him not very important medically but nevertheless must be made in order to assure some group of patients better treatment. A few men are instinctively equipped to understand the mental problems of their neighbors and to give sound advice to those whose souls are troubled. This number is smaller than is sometimes thought. We are too ready to assume that because we are all born equal—that is, equally helpless—therefore we must all have the same ability when we grow up. Certainly this is not the case. Able hospital administrators need a sound personality but in addition to that, they need much experience. Dr. Williams has maintained through three decades the reputation of continuous searching for the best methods of treatment and the conscientious and laudable attitude of subordinating everything else to the measure that he is satisfied is likely to bring greatest benefit to his patients.

In medical matters knowledge is not fixed and practice changes. So many varied measures must be employed in the treatment of our patients! Many of these measures may be poorly used unless we get skillful, trained people to apply them. To get the best results it is necessary to study incessantly and in a large hospital much of this study needs to be well organized. Training must go on continuously since turnover from death, retirement and resignation is always creating vacancies. Members of the medical staff may from time to time be sent away to some educational center where they can learn the views of others and the newer ways of doing things. The same arrangement may be made for the dietitian and social worker and the laboratory technicians, because there are very few of them. When we come to the ward personnel, it is a different story. There may be several hundred in one institution and the training must be done where they work. The best hospitals do much of it, and of course some poor hospitals do very little.

Let me remind you that Dr. Williams has always shown deep concern for the education of the nurse and the attendant. They are the people who spend the most time with the patients and the skill of their work is reflected in mental comfort of mental misery. Pupil nurses have received training here

for a long while, and for more than eight years affiliate pupils have been coming from general hospitals to round out their experience by a few months of psychiatric nursing. Short and practical courses have been given to attendants to increase their usefulness and efficiency. To one from another part of the country, interested of course in the development of the skills of our colored population but not especially familiar with their achievements or their difficulties, it seems particularly noteworthy that Dr. Williams has broadened the medical resources of the colored folk in all this area by setting up nurse training for suitable young people. So far as I know, this was the first mental hospital to establish a training course, though others—notably one in Virginia—have employed creditable numbers of colored graduates of other hospital schools. Of all those trained here some stay in the service of the hospital; others give almost more than they get while in training, as do all pupil nurses, and then pass on to other work. Out of my own experience I can assure you that a hospital that has a teaching program is usually a better hospital than one that does not. The presence of eager young folks inquiring "Why do you do it this way?" is a spur to our thinking and encourages us to improve our practices.

Much needs to be learned. We already know a great deal about disease, but there must be a vast deal more. How shall we find out what we do not know? Some of it by hard work, the observation of our patients and the application of personal experience, but other things—and sometimes the most important things—have to be dug out by people particularly endowed with the capacity to inquire and to deduce, men who have a well developed research mind. This term connotes a great deal of intelligent curiosity and the ability to put observations together so as to give the rest of us helpful conclusions. Some administrators are a little fearful of persons with such a bent. Indeed a beautifully done play was on the boards in New York a few years ago, showing the essential conflict in a hospital where the ratio was one physician to 750 patients and the superintendent begrudged any minute given to research, because that minute must be taken away from the attention needed by some patient. Progressive administrators wish to have research under way, knowing that an atmosphere of research is stimulating to the whole staff. Research may be done in the ward as truly as elsewhere, but in these days every physician likes to have good laboratory facilities, so that what he observes may be checked against the readings on some instrument of precision. To make progress in this direction, one must set up suitable facilities, then corral a person with a research mind, and give him opportunity to work on the problems that interest him.

Around 1931 Dr. Williams and an officer of the United States Public Health Service were discussing the use of malaria in mental hospitals. It is now generally known that one of the most deadly mental

disorders can often be arrested if the patient is subjected in proper fashion to a course of malarial paroxysms. The fact was known then but better procedures were desired. A very profitable joint enterprise was set up. The profit was not personal for Dr. Williams nor for the officers of the Public Health Service who worked on these grounds, but there was benefit to many mentally ill persons not only in South Carolina but as far away as the Pacific Coast.

The Surgeon General of the U. S. Public Health Service, Dr. Thomas Parran, sends his greetings to this assemblage and directs me to express his esteem for Dr. Williams and his deep appreciation of the years of collaboration between your staff and ours. Some of your physicians had a large part in this work and all benefitted from the stimulus that comes out of a fine project combining research and service. So Dr. Williams established here the tradition and appreciation of research. Years ago he confided to us his ambition to push on and develop research in other psychiatric problems. A few years back he showed me a building in which the research work was to be suitably housed. His colleagues in the American Psychiatric Association honor the spirit and ingenuity that have brought such things to pass.

One might talk of other things that have made this hospital stand out in the last 20 years, such as the wide freedom accorded to patients on the hospital grounds, the service of food hot (apparently a very simple matter but one that is fumbled in many institutions), encouragement to outside physicians to take up quarters in the hospital and spend a while on some problem, the considerable number of out-patient clinics maintained. But these remarks

are not intended to be a catalogue of excellencies, merely a statement of the esteem that hospital men have for Dr. Williams' work, with only a few specifications. For years we were in the habit of telling inquiring persons that the best public mental hospital in the southeastern section of the country was the one presided over by Dr. Williams.

The Association that I represent came to you a few years ago and borrowed no small amount of Dr. Williams' time and thought. He served us as president, for several years as a councillor, and has continued as an honorary officer. The Association has relied on him for good judgment on ticklish questions. He was a member of the special committee that rated the candidates for the superintendency of the great St. Elizabeths Hospital. We thank you for granting us his time, his interest, his analytic ability and his sincere judgment on the problems that have faced us. Since problems seem to multiply in these troublous days, we pray that you will continue to encourage him to sit with our Council and guide us by his long and fine experience. We do not lack brash youth, and a Nestor is always needed. In representing the American Psychiatric Association, you see, I come not merely to congratulate you on what has been done but to ask for something more.

It is a privilege and a pleasure to sit with you on an occasion like this. I am happy to bring you the personal greetings of a great medical society. More than that, I bring you assurance of the high regard and affectionate respect in which Dr. Williams is held by a great number of physicians who now or at some other time have given special attention to disorders of the mind.

Samuel W. Hamilton, M.D.

DEATHS

Beverly A. Henry

Beverly A. Henry, 82, one of the oldest practicing physicians in the state and dean of the Anderson Medical Society, died at the Anderson Hospital on April 4. Going out to his car in the early evening to pay a call he suffered a stroke and expired a few hours later.

A graduate of Emory University School of Medicine (1886), Dr. Henry first practiced in Lowneville. In 1899 he moved to Anderson where he continued his medical work up to the time of his death. Dr. Henry, in addition to his practice, was a civic leader and a staunch supporter and worker in the church.

He is survived by his wife and two daughters.

Charles H. Burton

Charles H. Burton, 68, died at his home in Iva on May 2.

A native of Laurens county, he attended the Univ. of Georgia Medical School, graduating in 1902. After practicing medicine in Coronado and Ware Shoals, he moved to Iva in 1908 and remained there until his death. He was a true family physician and his passing brought sadness to a large host of patients and friends.

He is survived by his widow, the former Miss Annie Hughes.

Bascomb Lanier Chipley

Bascomb Lanier Chipley, 63, a native of Greenwood County, died suddenly May 13 enroute from Chillicothe, Ohio to New York. He was stricken with a heart attack and was removed from the train at Brunswick, Md. and died in that city.

Dr. Chipley received his degree in medicine from the University of Maryland. From 1942 to 1944 he was a member of the staff at State Park Hospital.

He is survived by his widow and one son.

The Ten Point Program

M. L. MEADORS, EXECUTIVE DIRECTOR AND COUNSEL

OTHER SOCIETIES NOTE OUR PROGRAM

As a result of the notice taken of our Program in a recent issue of the News Letter of the AMA Council on Medical Service and Public Relations, we have received requests from many sections of the country for copies of the Program and other information concerning it. Among others, such requests were received from the following organizations and individuals: The State Medical Societies of New York, Pennsylvania, Louisiana, Connecticut and Michigan; the Medical Societies of the counties of New York, Albany and Kings in the state of New York; Jackson County Medical Society, Kansas City, Missouri; The Division of Social Welfare of the Department of Social Security of Minnesota; The American College of Chest Physicians; Dr. W. F. Braasch, Rochester, Minnesota, a member of the Board of Trustees of the American Medical Association; Dr. Stanley Nichols, Long Branch, New Jersey; Dr. Harold B. Davidson, New York; The Clinic-Hospital of San Angelo, Texas; Dr. Edward N. Ewer, Oakland, California; Dr. R. J. Hubbell, Kalamazoo, Michigan; Dr. J. Stanley Kenney, New York; Dr. Herbert L. Mantz, Kansas City; The Bureau of Medical Care Insurance, New York and Dr. Louis A. Buie of the Mayo Clinic (Dr. Buie is a native South Carolinian).

Needless to say, all of the requests were promptly complied with. Among the comments received in response are the following:

From Dr. Buie—"You have asked for my reaction after studying this Program and I am very glad to inform you that I approve of it highly."

From Dr. W. P. Anderton, Secretary of the Medical Society of the State of New York: "Allow me through you to congratulate the South Carolina Medical Association for this comprehensive and public spirited program."

From Mr. George P. Farrell, Director of the Bureau of Medical Care Insurance of the New York State Society—"Your pamphlet sets off the aims and ambitions of the Medical Association and I can say without reservation that your program should result in what the medical profession throughout the United States is striving for; namely, good and adequate medical care within the reach of all the people."

From Dr. Vincent T. Williams, Editor of the Weekly Bulletin of the Jackson County Medical Society (Missouri)—"After persuing it thoroughly I am convinced that this text reveals by far the best means of public relations with which I have come in contact. This is a subject in which I have been most interested for a number of years. I am going to show your program to our County Society in the near

future and see if we cannot get some similar action started in our County and possibly in our State."

"REALISM IN PUBLIC RELATIONS"

A paper under the above title prepared by Dr. Joseph S. Lawrence was printed in the Pennsylvania Medical Journal and a reprint appears in the May issue of New York Medicine, the official publication of the Medical Society of the County of New York. Dr. Lawrence is in charge of the Washington office of the American Medical Association and served for many years as Executive Officer and Legislative Representative of the New York State Medical Society.

In his paper he discusses the need of fostering public relations on the part of the profession and states some of the reasons why the average physician feels little interest and is often unqualified in the subject. He observes:

"The student's ambition on completing his education is to become a great scientist or specialist, and he hopes the public will learn of the great work he is hoping to accomplish. His responsibility as a learned member of the community is never stressed in his training, so that later in life when he may be drawn into public life, he very often loses his patience with people who will not see things as he sees them. He will tell the legislators how the laws should be written; he does not ask 'Could it be done this way or that?' If they differ from him, he thinks it is because they are politicians. It rarely occurs to him that the public should be consulted; it needs only to be told. If it refuses to follow the directions given, but wants to discuss the proposition, the physician loses patience and usually withdraws with the declaration that 'you can't get anywhere with that bunch of numbskulls.' His unwillingness to compromise manifests itself in his discussion with his fellow men."

Under the heading "Why a Public Relations Program?" Dr. Lawrence then continues:

"Recently I have listened to quite a few discussions on the merits of service and indemnity insurance plans. The advocates of each plan will describe the merits of their plan and close their minds to the arguments of the other. The service advocate challenges the ethical spirit of the indemnity advocate, who in turn characterizes the other as 'impractical.' They will retreat from the meeting firing their small guns at each other, neither having been convinced by the arguments produced by the other. This spirit of aloofness is resented by the public; they would be friends with the physician, drawing upon the experience they have with their family doctor, but because of the attitude of indifference shown by many phy-

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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*

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sicians, the public has learned to characterize them as being aloof and impractical.

"Why should we have a public relations program, and why should the physicians be interested in it? Because every question has at least two sides to it, and it takes two in a party to make a contract. This is a matter that many physicians need to take seriously. Not long ago I called upon a senator to discuss the future of medicine and he stressed very forcibly the need, as he saw it, for the physicians or the medical profession to make more effort to give the public a better understanding of the problems involved in providing medical care. He said: 'You physicians know this problem thoroughly, and why should you keep it to yourselves?' He was asked how it could be given to the public. He suggested that the newspapers and public speakers could be used. He said: 'How do other people get their ideas before the public?'"

Referring to his experience in connection with his work in Washington Dr. Lawrence says, "Let's Be Practical:"

"In speaking with some congressmen recently, they assured me that they are not interested in having the government engage in the practice of medicine. They disapprove of using tax money to pay physicians for medical services. 'But,' they said, 'let's be practical in this matter. The public, as shown by the polling statistics, is interested in having certain changes, among them a reduction in the cost of medical care or a program by which an easier method of paying for those services may be devised, also an increase in the number of physicians or the making of medical service more available to the white-collar class.' In a group of physicians not long ago the need and demand for these changes was questioned. These particular doctors said that none of their patients had come to them complaining of exorbitant bills or of inability to get medical care. I believe that this is true, but on the whole there is a strong feeling that something must be done, and here is our opportunity to begin our public relations program."

"Those who are interested in having the government change the practice of medicine have taken all of the various groups that are available into their confidence, selling their propositions to the farmers, to laborers, and to agitators. Even government employees are led to believe from stories and arguments presented that they should have their medical care at less expense and much more readily available. How they would accomplish this I do not know, but I don't think that is the problem at this time. The real problem now is that we are being misrepresented and we are saying too little about it."

Dr. Lawrence suggests the following:

"1. Increase membership in our county and state societies or associations and thus increase membership in the American Medical Association.

2. Give thorough and careful consideration to all propositions offered, condemning none because of

personality.

3. Develop unity of thought regarding propositions.

4. Consult through the medium of the county society with community leaders, official and non-official, regarding problems of medical service and public health."

INSURANCE PLANS

The following is from a recent news letter of the Council on Medical Service and Public Relations, AMA:

"Doctors are becoming *insurance conscious*. Meetings throughout the nation buzz with prepayment health insurance talk. 'Indemnity,' 'service,' 'mutual,' 'non-profit,' 'payroll deduction,' 'catastrophic illness' and 'coverage' are rapidly becoming familiar terms, and even the most casual passer-by can't help but notice that often the discussion is not only *factual*—but *heated*, and that although almost as many *varied shades* of opinion exist as there are discussers, generally the groups divide themselves into *three schools of thought*:

First—Those favoring non-profit service plans.

Second—Those favoring cash indemnity plans.

Third—Those who do not want anything at all to do with any kind of insurance plan."

"*Increases* in membership in these plans within the last year *have been dramatic*. An example of this is that the chart shows Michigan to have had 467,717 members in 1943 while Michigan spokesmen state that number is 772,534 as of January 31, 1945. The *Washington State* plans, some 18 in number and among the oldest in the country, were among those not listed. These Washington plans report some 250,000 subscribers."

Elsewhere in this department is a review of a recent article describing the purposes and experience of the Michigan Medical Service Plan, one of the chief pioneers along this line.

The Rhode Island Medical Journal for April carries a complete copy of the Bill introduced in the General Assembly of that State on March 13, 1945, providing for the incorporation of non-profit medical service corporations and defining their powers.

The structure of the proposed organization is generally similar to that of the "Blue Cross" plans, it being provided that a majority of the directors must at all times be doctors of medicine, duly licensed under the laws of Rhode Island. The bill was referred to the Committee of Judiciary and presumably had not been reported out when the Journal went to press.

The survey of the Michigan plan referred to above was printed in the Journal of the Ohio State Medical Society. It was of particular interest there because of the fact that Ohio is working out a plan for a similar purpose although to be operated along somewhat different lines than in Michigan. The Ohio



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plan, according to our information, is to be operated on an indemnity basis.

According to the same news letter referred to above, the Bureau of Legal Medicine and Legislation reports, on the basis of advice from its Legislative Reporting Service, that "*laws authorizing organization and operation of non-profit medical service plan corporations have been enacted in Tennessee, Iowa, and North Dakota. Similar bills are in process of enactment in Kansas, Minnesota and South Dakota. In addition a law permitting a non-profit hospital service corporation to operate a supplementary medical service plan in conjunction with a hospital service plan has been enacted in West Virginia. No other similar bills are pending today, according to available information.*" (This was on March 22, at which time evidently information had not been received on the Rhode Island Bill.)

According to the same source last referred to, prepayment plans in some form, operated either separately or in conjunction with "Blue Cross" Hospital Service plans, and principally controlled by the medical profession, are in operation in 17 states. There are 20 plans in all, there being 3 in the State of New York and 2 in North Carolina. The other states are Massachusetts, Michigan, Missouri, Pennsylvania, Colorado, Texas, Delaware, California, New Jersey, Wisconsin, Connecticut, Kansas, Ohio, Iowa, and Indiana.

COMPULSORY HEALTH INSURANCE LEGISLATION IN CALIFORNIA

The recent or current session (our information does not show whether it has adjourned) of the California General Assembly had before it for consideration no less than three separate bills relating to health insurance. Two of these, one sponsored by Governor Warren and generally regarded as his personal project and the other fostered by the CIO, provided for compulsory health insurance with payroll tax deductions, and contribution by the employers to supplement those by the employees, along the same general principles as in the Wagner-Murray-Dingell Bill. The third was fostered by the California Medical Association and attempts to provide adequate health insurance on a voluntary basis.

According to the news items and editorials reported in a recent issue of California and Western Medicine, the Journal of the CMA, the compulsory "all-out" bills met with comparatively little favor and the threat was made openly to carry the issue to the people in the elections of 1946 if the General Assembly did not pass one of the bills this year. We do not know at this time whether the bill of the California Medical Association fared any better at the hands of the General Assembly. Senator Murray, one of the co-sponsors of the Wagner-Murray-Dingell Bill, was quoted in the San Francisco News of February 13th

as having stated, "California is outstanding in giving serious attention to such bills. If one of the bills or some combination of bills should be enacted the pattern that is adopted in California is likely to have far-reaching influence on what happens in other states."

Also "The American Medical Association and its political stooge (the National Physicians' Committee) are merely fighting a rearguard delaying action. I suspect they are hoping that if they can have health insurance come slowly enough and with enough muddling, it won't amount to anything when it is adopted and they will be in control of it."

Our most recent information on the subject comes via the May issue of Medical Economics which states that both Governor Warren and the CIO "received a sharp setback in their campaign for the establishment of a compulsory health insurance system. The Assembly committee which had been considering their bills tabled them by a vote of 7-3, and the Assembly itself rejected a motion to bring them to the floor by a vote of 34-12 on the CIO measure and 38-39 on the Warren Bill. The twin action had the effect of killing any compulsory health insurance legislation in the current session."

Anent the threat to carry the issue to the public through an initiative petition in 1946, John M. Hunton, executive secretary of the CMA, is quoted as having said, "I think it is time we called that bluff. If the CIO wants to submit this measure to the people, then by all means let them get at it. The doctors of California have complete confidence that the voters will reject state medicine by an overwhelming majority."

MEDICAL SERVICE IN MICHIGAN

According to an article reprinted in the April issue of the Ohio State Medical Journal, from the Detroit Medical News, Michigan medical service is starting on its sixth year of actual operation. It began with less than \$20,000.00 to invest in setting up an organization and, according to the writer, "comparatively less in actuarial figures or ideas on how to run such an organization." The article admits that the corporation had a stormy beginning and had to cut back from its original plan for over-all care to the present surgical contract; also that it has had to battle for its existence both within and without the medical profession. Despite this, its situation today appears to be very favorable.

As of January 1, 1945, \$9,484,285.12 had been paid out for services to its clientele. During the year 1944 it paid to the physicians of Michigan for services rendered, the sum of \$3,437,265.50. "As of present writing, Michigan Medical Service has no outstanding indebtedness except current bills and \$2,302.84 unpaid on former prorated fees (cases in which the corporation is unable to ascertain the person to whom the amount should be paid). The corporation owns \$500,000.00 in government bonds and has cash on hand and in bank of \$609,828.01. In 1944, the premiums earned amounted to \$4,512,-



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755.87 and the cost of administration of the plan amounted to 11.44% of income and about 80% of income was paid out for services rendered to the subscribers. An adequate reserve has been set up to cover unreported services and a good beginning has been made on developing a surplus fund."

When the article was written (March, 1945) there were 295,478 outstanding contracts providing surgical coverage to 717,420 persons in Michigan. This is an average of better than 1 out of 8 persons in the state. Sixty thousand and three hundred new contracts were written in the past year. "In the official Michigan Insurance Report on the leading health and accident insurance companies doing business in the state, Michigan Medical Service was third in premium income and second in claims paid, Michigan Hospital Service holding first place in each classification."

The plan is operated on a service basis with participating physicians, for the individual of under \$2,000.00 annual income or the family of under \$2,500.00 income. More than 65% of the physicians in Michigan are participating and a large percentage of non-participating doctors accept the service fees in full for these lower income groups. "The fees paid are established by an advisory board composed of participating and nonparticipating physicians and with the exception of appendectomy (\$75) and tonsillectomy (\$25) are equal to or better than most plans. The fee schedule is elastic so that individual cases may be adjusted by these advisory boards."

Contracts are written for groups but on such basis that an individual changing position or group may continue his contract by paying his premium individually. Reciprocity agreements are maintained with 14 other service plans throughout the country. At present, a new medical and surgical contract is in the process of formation to cover all medical as well as surgical care while hospitalized and this will be put in force shortly at a very slight increase in premiums.

After covering adequately other phases of the plan's operation, the writer in the Detroit Medical News concludes: "In conclusion, we ask the editors of our medical journals not to print cynical criticisms regarding any of the plans their fellow physicians are attempting until they have some knowledge of what they speak. All of us are striving to do our best for the medical profession and for their patients. We will all make mistakes but those making mistakes are at least trying to solve the problem and not adopting a defeatist attitude."

"Remember, it is private business, no endowments, no gifts and no Federal loans or funds."

MEDICAL FORUM

The Wisconsin Medical Journal includes each month a department entitled "The Medical Forum" devoted to a survey of the political, economic and legislative phases of medical practice in the different

states, which is highly interesting and informative. The Wisconsin Society and the Editors of the Journal are to be congratulated on the comprehensive treatment being given the subject. A number of their news articles and comments bear directly on the subjects with which we are concerned.

The March issue carried the following quotation from and comments on correspondence between Mr. Theodore Wiprud and Dr. John H. Fitzgibbon:

"Every leader in medicine recognizes that there are deficiencies in the present system of providing medical care which should be corrected," declared Theodore Wiprud, secretary of the Medical Society of the District of Columbia, in a recent communication to Dr. John H. Fitzgibbon, Portland, Ore., chairman of the Council on Medical Service and Public Relations of the American Medical Association.

Both Wiprud and Fitzgibbon have given permission for the release of the views expressed by Wiprud, who states further: "For more than a decade, the American Medical Association has been on the defensive in dealing with social and economic aspects of medicine. True, it has approved changes in this field, but oftener than not under pressure. I have in mind the so-called medical indemnity and medical service plans. It was, of course, well known that medical plans of any kind were an anathema to the American Medical Association for a long time and consequently inevitable approval was put off for several years. That is one reason why many people look upon us as obstructionists and view what we say and do with skepticism."

Wiprud, who formerly served in the business management of the clinic of Dr. R. G. Arveson, Frederic, and later as executive secretary of the Medical Society of Milwaukee County, is well known. While acknowledging advice and assistance given by the AMA to medical organizations developing prepayment plans, Wiprud asserted that the national organization has failed to provide leadership in the field.

"Unless the AMA is willing to present to the country a national health program," declared Wiprud. "I feel we are in for a rough time. It doesn't need to be a radical program but it must be constructive. The argument that no single program will meet the needs of all communities of all parts of the country is admittedly correct so far as details of operation are concerned. Basic elements of a program, however, can be developed which are applicable to the nation."

Expressing his belief that the Council on Medical Service and Public Relations of the AMA possesses great potentialities, Wiprud urged council consideration of developing a "nationwide voluntary sickness insurance program" with a director to carry out the undertaking.

"A tremendous effort will be put forth in the next few months," said Wiprud. "to enact health legislation which we do not favor. There is only one way to meet this effort and that is to offer a program

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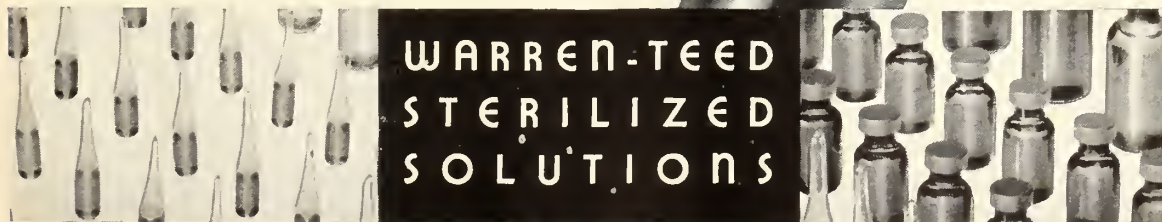
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ourselves. And I do not mean an appeasement program but a genuine health program in which we wholeheartedly believe."

BUREAU OF MEDICAL CARE INSURANCE IN NEW YORK

"In a move to bring voluntary insurance for medical care within the reach of every citizen of the state, the Medical Society of the State of New York began operation of a bureau of medical care insurance Feb. 1, with George P. Farrell, of Buffalo, as director.

The new bureau, which is located at the medical society's offices in New York City, will act to coordinate the medical-surgical care insurance plans

already operating in the state under medical society sponsorship and to form new ones in areas not yet served by the existing plans. It will also compile and distribute information and statistics to local medical insurance organizations throughout the state and supply them to physicians.

The establishment of the bureau of medical care insurance follows 4 years' study by the Medical society of the State of New York of voluntary medical indemnity insurance. There are already in operation in the state three medical society sponsored plans for prepayment of medical care — United Medical Service, Inc., serving New York City and surrounding areas; Medical and Surgical Care, Inc., serving Utica and vicinity; and the Western New York Medical Plan."—From the Medical Forum, Wisconsin Medical Journal.

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Pathological Conference, Medical College of the State of South Carolina

KENNETH M. LYNCH, M.D., PROFESSOR OF PATHOLOGY

ABSTRACT NO. 445

Student H. M. Carter, Jr. (Presenting):

History: Six months before admission, this 37 year old colored man began to have slight malaise which in no way curtailed his activity. This continued and two months before admission, his legs began to swell, and about the same time he had a "heavy feeling in the stomach" accompanied by "the fever" which necessitated his stopping work, and at times remaining in bed. Two weeks before admission, he noted a swelling in the epigastrium for which he took soda with no relief. Also, said for past two months urine had been dark red to brown.

Physical Examination: T. 99.6°, P. 98, B. 24, B. P. 145/95. Well developed, poorly nourished colored man. There was limitation of expansion of the chest (explained as being due to epigastric mass), and the lung borders were high with limitation of downward excursion of diaphragm. Heart negative. Abdomen: large, tender, nodular mass filling the epigastrium almost as far down as the umbilicus, extending 2-3 cm. to the right of the midline and within 4 cm. of the lateral abdominal wall on the left. The mass descended with respiration. To the right of the mass was a tympanitic area and the abdomen below the umbilicus had a dull percussion note with signs suggestive of fluid. G-U and rectal examination negative. There was 2 plus pitting edema over the sacrum and 3 plus pitting edema of both legs.

Laboratory Examination:

Urinalyses: Reddish yellow to brownish red, 1,023-1,027 Sp. Gr., 2 plus albumin, 3-5 WBC/HPF, 0-1 RBC/HPF, 1-2 plus granular and hyaline casts, & 1 plus pus cast (once).

Blood Count: 10,900-9,000 WBC, 3.3-3.6M RBC, 7-6 Gms. hbg, 65% polys, 27% lymphs, 7.5 monos., 5 eos.

Feces: Light green to light brown 3 plus-4 plus mucous, 2 plus-3 plus occult blood.

Blood Urea N. 14 Mg. (3-5); Serum Amylase 64 units (3/11); Sugar 59 mg. (3/5); 55 mg. (3/11).

Total Serum proteins 6.95 gms. (3-5), 4.53 gms. albumin, 2.42 globulin.

Exton Rose Glucose Tolerance Test: 1st. 50 mg; 2nd. 73 mg; 3rd. 100 mg—second urine specimen 1 plus sugar.

Course: Patient remained about the same. Paracentesis on 3-11 (eight days after entry), yielded only 3 oz. of straw-colored fluid. Operated on 3/14. Steady downhill course to death on 3/22.

Dr. W. H. Prioleau (conducting): Mr. Joseph, what is your analysis of this case?

Student Joseph: The discussion of this case revolves about the abdominal mass. Its description indicates that it is probably the liver. This man falls into a slightly younger age group than do the majority of metastatic neoplasms of the liver and primary hepatic carcinoma would be even more unlikely. The chances are that if the tumefaction is due to neoplasm, it is probably secondary. The presence of blood in the stools indicates that the most likely primary site is the stomach. Gumma of the liver is practically eliminated by the negative Wassermann and Kline. Tuberculosis of the liver is improbable in view of the absence of any pulmonary signs or symptoms. Primary amyloidosis is very rare, and I am unable to support or deny this possibility without such diagnostic aids as a Congo Red Test.

Dr. Prioleau: How do you explain the anemia?

Student Joseph: The anti anemic factor is elaborated in the gastric mucosa and stored in the liver. Extensive involvement of the stomach may interfere with the production of the antianemic principal and severe liver disease may prevent storage of the hematinic principal. It follows that two reasons for the anemia may be present here.

Dr. Prioleau: What explanation can you offer for the fever and urinary findings?

Student Joseph: The fever could be produced by infection of the tumor in liver or stomach. There is also frequently necrosis of tumor tissue with liberation of protein matter that is toxic. The urinary findings are more difficult to explain. Dehydration due to inadequate fluid intake and the fever will account for some of the changes, but not for the erythrocytes and leucocytes.

Dr. Prioleau: Mr. Bolin, do you agree with what has been said?

Student Bolin: Carcinoma of the colon or pancreas with metastases to the liver seems more likely from the history. The gastric symptoms should be more pronounced if the stomach is the primary site. Primary carcinoma of the liver is rare, but when it does occur it may be in the left lobe which would be consistent with the description of this mass. The blood in the stools is inconsistent with this diagnosis, however. The edema has not been discussed. If the mass produced obstruction of the inferior vena cava there would be edema of the feet and legs, whereas blockage of the portal system would cause ascites and edema of lower extremities. It appears that the latter part of the circulatory system was involved here.

Dr. Prioleau: Mr. Jennings, is there any detail in this case that struck you as unusual and of possible significance?

Student Jennings: The hypoglycemia is unusual and made me wonder about a tumor of the islet tissue of the pancreas, but these are rare and it would be even more uncommon for one to metastasize.

Dr. Prioleau: I feel that the most important symptom is the edema of the lower extremities. A retroperitoneal tumor in the region of the root of the mesentery might compress the vena cava and could also move with respiration if of sufficient size. The stomach symptoms do not ring true as regards carcinoma of the stomach and could be due to pressure.

Dr. Kredel: I wish to cast my vote for hypernephroma. It is a tumor that will produce a mass in this region and shows a pronounced tendency to invade veins.

Dr. Smithy: I wish to say a word about the anemia in gastric carcinoma. For years we have placed reliance on a macrocytic anemia. Pack and his co-workers have found that macrocytic anemia in carcinoma of the stomach is exceptional, and when it occurs it differs in many respects from true Addisonian anemia.

Dr. Cannon: Final Pathological Diagnosis: *Primary Carcinoma of the Liver.*

We do not consider primary carcinoma of the liver a rare entity in this department as we have about 18 cases in our files. It is unusual for primary liver carcinoma not to be associated with cirrhosis, however, and this case is of that type. We have had only two other such cases and both of these were in children. The liver weighed 3550 gm. and its left

lobe and the mesial portion of the right lobe was replaced by a confluent irregular, nodular grayish-tan neoplastic mass with fibrous trabeculations. Invasion of the portal vein and its branches was a prominent finding grossly and microscopically. Histologically the tumor was composed of irregular polyhedral

cells, bearing a striking resemblance to cords of liver cells in some areas. The tumor was so situated that it could have compressed the vena cava, but no obstruction was demonstrable at autopsy. The only metastatic focus was a small microscopic nodule in one lung.

NEWS ITEMS

NEWS ITEMS

Dr. Sam Pruitt, a native of Anderson and a practicing physician in Pennsylvania and North Carolina for a number of years, has returned to Anderson and will practice his profession there.

Lt. Comdr. F. O. Weston of Columbia and Mullins, has been transferred from the Columbia area to a Naval Hospital post on the Pacific Coast.

Dr. Orin R. Yost, who was recently retired from the Army, has opened offices in Columbia. His practice is limited to psychiatry.

Captain Gertrude Holmes was a recent visitor in Greenville.

MEDICAL SOCIETY MEETINGS Six-county Society

The Six County (Darlington, Dillon, Florence, Chesterfield, Marion, Marlboro) Society held its monthly meeting at the Florence Army Air Field on May 17 with Dr. Joe Cain of Mullins presiding. This society, recently organized, is receiving enthusiastic support from all the participating counties.

Dr. John A. Boone of Charleston was the guest speaker of the evening and presented a paper on "Peptic Ulcer in Congestive Heart Failure." The local paper was presented by Dr. Harold Gilmore of Nichols and consisted of a review of the recently published "Penicillin and other Antibiotic Agents," by Wallace E. Herrell.

BIRTH ANNOUNCEMENTS

Dr. and Mrs. T. L. Takacy of Slater, announce the birth of a son on March 25.

Dr. and Mrs. George R. Dawson of Florence, announce the arrival of a daughter on May 1.

Dr. and Mrs. C. K. Lindler of Columbia, announce the birth of a son on April 2.

Dr. and Mrs. J. L. Hughes of Greer, announce the birth of a daughter on April 3.

BOOK REVIEWS

CLINICAL HEART DISEASE

By Samuel A. Levine, M.D.

W. B. Saunders Company, Philadelphia-London

This, the third edition since its original publication in 1936, of Dr. Levine's Clinical Heart Disease, continues, as the author states, to be a simple discussion of the common problems of heart disease, constantly bearing in mind the viewpoint of the general practitioner.

This book bears witness of Dr. Levine's vast experience and years of teaching in the Harvard Medical School. The bedside diagnosis of the common cardiac disorders is particularly stressed along with their treatment and management.

The chapter on electrocardiography has been am-

plified, many new electrocardiograms are included and there is a lucid and detailed discussion of the precordial leads.

One chapter deals with the acute cardiac emergencies with emphasis on the signs and symptoms that enable the attending physician to make a definite bedside diagnosis and institute appropriate therapy. Other informative chapters, in addition to those in which the different forms of heart disease are taken into consideration, discuss the medico legal aspects of heart disease, the clinical significance of the systolic murmur, the patient with heart disease is a surgical or obstetrical risk, and factors concerning prognosis in heart disease.

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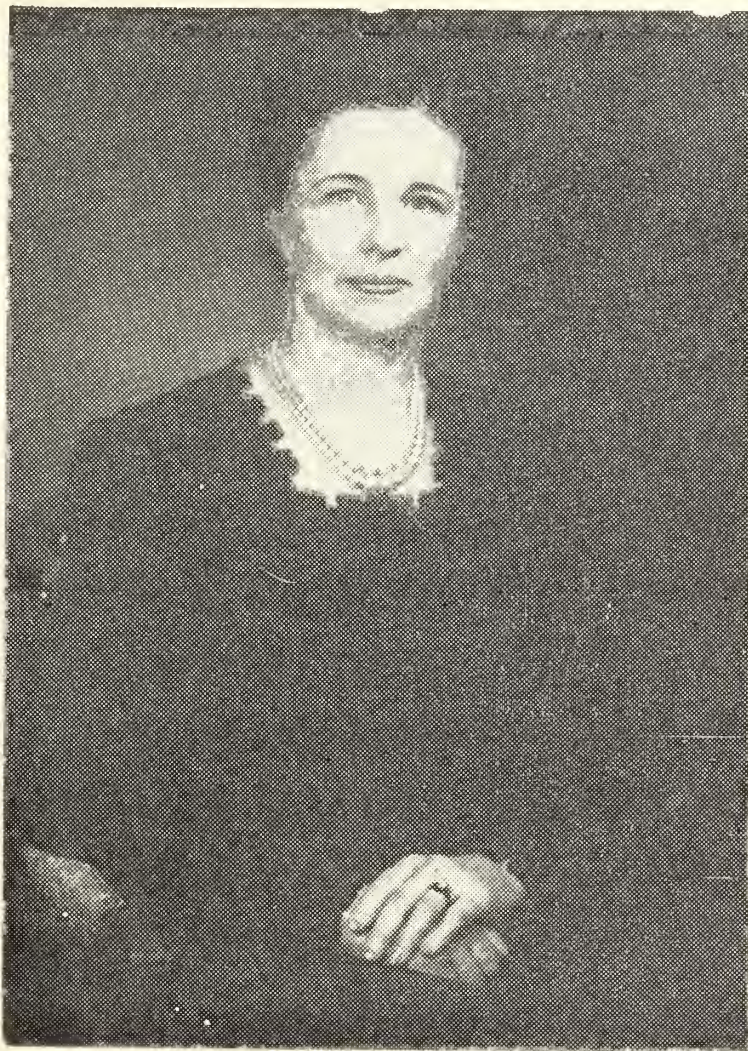
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WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. Vance W. Brabham, Orangeburg, S. C.

Publicity Secretary: Mrs. J. C. Josey, Spartanburg, S. C.



MRS. VANCE W. BRABHAM

President of the Woman's Auxiliary to the South Carolina Medical Association

Mrs. Vance W. Brabham of Orangeburg was installed as President of the Woman's Auxiliary to the South Carolina Medical Association at an Executive Board Meeting held in Spartanburg on April 17th. Other officers installed were Mrs. S. Harry Ross of Anderson, president-elect; Mrs. David F. Adcock of Columbia, first vice-president; Mrs. J. W. Potts of Easley, second vice-president; Mrs. J. R. Desportes of Fort Mill, Historian; Mrs. J. C. Josey of Spartanburg, Recording Secretary; Mrs. J. L. Sanders of Greenville, Treasurer; Mrs. W. C. Abel of Columbia, Counselor of District No. 3; Mrs. W. H. Folk of Spartanburg, Counselor of District No. 4 and Mrs. J. L. Bundy of Rock Hill, Counselor of District

No. 5.

Mrs. Brabham outlined plans for the coming year and urged all members to continue their interest in juvenile delinquency.

Mrs. W. H. Folk of Spartanburg, the retiring president, presided over the meeting. During the business session various matters were discussed and reports from State Committees were made.

Following the adjournment of the meeting, the members of the board from Spartanburg entertained with a luncheon at the home of Dr. and Mrs. J. C. Josey on Twin Drive honoring the new State President, Mrs. Vance W. Brabham, and the President-

elect, Mrs. S. Harry Ross of Anderson, Mrs. Josey and Mrs. William H. Folk, the retiring state president, greeted the guests as they arrived. Mrs. P. M. Temples, Mrs. W. T. Hendrix and Mrs. H. W. Koopman, invited the guests into the dining room. At a beautifully appointed luncheon table overlaid with an imported maderia cover and centered with an arrangement of shell pink peonies, Japanese iris and snapdragons, flanked with lighted green cathedral tapers, a delicious luncheon course was served. Small tables decorated with star crystal bowls containing candles with roses and syringa at their base were arranged in the living room. Miniature antique china slippers, holding rosebuds marked each guest's place.

At the Executive Board meeting of the Woman's Auxiliary to the South Carolina Medical Association held in Spartanburg on April 17th, three trophies were awarded. The Furman Health Trophy was presented to the Pickens County Auxiliary for their outstanding work in Tuberculosis. The Strait Historical Trophy was presented to the Greenville County Auxiliary for the best paper; the story was on Old Chick Springs, written by Mrs. Richard M. Pollitzer of Greenville. The T. R. U. Wilson Publicity Trophy went to the Spartanburg County Auxiliary for submitting the best scrapbook. This being the third consecutive year the Spartanburg Auxiliary has won this trophy, it will be permanently kept by the auxiliary.

PUBLIC HEALTH NEWS

CHARLESTON COUNTY HEALTH DEPARTMENT OBSERVED 25TH ANNIVERSARY IN APRIL

The Charleston County Health Department celebrated its 25th anniversary last month.

Since the department's creation in April, 1920, the staff has grown from five members to 87, including those affiliated with city, state and federal systems.

Dr. Leon Banov, Health Officer, has held the position since the department was organized. Others of the original five who have been with the department since its beginning are Miss Nellie Mood, Clerk, and Mrs. Silas S. Welch, Sanitary Inspector.

In 1926, the county and city health departments were consolidated under Doctor Banov, and ten years later the city department was abolished, giving the county group charge of health for both the city and county of Charleston.

Officers of the department were situated first in a building at Meeting and Society Streets. A few years ago the entire set-up was moved to the new county Center in the old Citadel.

The Health Department's staff now includes the following: 55 county employees; 13 federal employees; 11 nurses and venereal disease workers employed by the State Board of Health; 5 state employees on malaria control; 2 district consultants; and one city typhus worker. In addition, some 50 laborers are employed by the City and State to assist with the various programs.

DR. WYMAN OUTLINES DUTIES OF DIVISION OF FINANCE

The following statement concerning the organization and duties of the Division of Finance is presented by Dr. Ben F. Wyman, State Health Officer,

for the information of all personnel of the State Board of Health and county health departments:

"As of April 1, 1945, by authority of the Executive Committee and with funds made available by the State Legislature, the Division of Finance was organized under the leadership of Mr. John O. Meetze as Director. Mr. Meetze, also by the authority mentioned, has been given the authority for the payment of all salaries and travel under his signature as Director. This procedure of authorization and payment also refers to all items of supplies, equipment, etc.

"In order that all personnel may be fully aware of the duties and responsibilities of Mr. Meetze, the following statement is made. As director, Mr. Meetze has charge of all personnel in the Division of Finance. He has control of all fiscal affairs of the State Board of Health, except any activity connected with the South Carolina Tuberculosis Sanitarium. This control not only applies to all funds made available to the State Board of Health by the State but also all Federal funds. It also includes such funds as those secured from the Federal Government for the public health hospitals for the treatment of venereal diseases, and funds for the operation of the S. C. Convalescent Home for Crippled Children at Florence.

"In addition to the above duties, Mr. Meetze will be in charge of all supplies, whether office, medical, or venereal disease supplies. Disposition of these supplies will be on proper requisition signed by the head of each Division and after proper approval, will be handled by the Service Officer, Mr. William N. Geiger, under Mr. Meetze.

"I wish to emphasize the importance of the proper control of all fiscal policies and activities of the State Board of Health, and I have directed Mr. Meetze to assume, under my supervision, full authority over all matters pertaining thereto."

Wyeth

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THE LITERATURE¹⁻⁴ stresses the high incidence of recurrence in peptic ulcer and the need of constant vigil against flare-up. A return to the ulcer regimen—special diet, rest, antacids, etc.—is said to be particularly advisable during spring and autumn¹ and following emotional storms.⁵

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*Reg. U. S. Pat. Off.

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1. Bockus, H. L.; Gastro-Enterology 1:471, 1943, W. B. Saunders Co., Philo. 2. Hurst, A.; Practitioner 152:193, 1944. 3. Berk, J. E.; J. Med. Soc. N. J. 41:365-370, 1944. 4. Rehfuess, M. E.; Indigestion, Its Diagnosis and Management, Philo. W. B. Saunders Co., 1943, pp. 241-243. 5. Alvarez, W. C.; Gastroenterology, 2:65-67, 1944. 6. Selye, H. and MacLean A.; Amer. J. Dig. Dis. 11:319-322, 1944. 7. Fouley, G. B., et al.; Arch. Int. Med. 67:563-578, 1941.

BRIGHTER OUTLOOK FOR CANCER CONTROL

Since 1915 the number of reported deaths from tuberculosis in South Carolina has declined from 1828, or 136.3 per 100,000 population, to 630 or 32.0 per 100,000 population. During the same period, deaths from cancer in South Carolina have climbed upward from 474, or 35.2 per 100,000 population, to 1205, or 61.1 per 100,000 population.

Thus we see that while we have been waging a successful fight against one arch enemy, another equally dangerous invader has been woefully neglected. It is encouraging to know, however, that both our State and the nation as a whole are becoming increasingly aware of the seriousness of our cancer problem and are taking definite steps toward a solution.

In South Carolina this year, the General Assembly appropriated \$50,000 for hospital care of indigent cancer patients — \$34,000 more than any previous appropriation for cancer control.

From a national standpoint, the American Cancer Society has begun a campaign to raise funds for organized cancer research that will give everyone an opportunity to contribute to this worthy cause and at the same time become better informed about the dreaded disease. In its hearty endorsement of the plan in the following editorial, Collier's reveals a few startling facts.

"In peacetime, some 1,400,000 Americans die each year; and of this number more than 10 per cent—about 160,000—are carried off by cancer. Cancer remains one of the most terrifying and mysterious of the common diseases.

"The impression has been pretty general that medical science was attacking the cancer mystery on a broad, well-organized front, with well-endowed laboratories, systematic collection and sifting of data, and so on. Unhappily, such has not been the case. Cancer research up to now has been handled mainly by a few big institutions or by individual scientists, generally with inadequate funds in both cases.

"The American Cancer Society hopes to change all that. It is setting out to raise a fund of \$5,000,000 by popular subscription, with which to put cancer research on its feet financially and get it organized as it ought to be.

"As we see it, the plan has two great merits. One, of course, is the heightened hope it should give the human race for an early discovery of some more effective method of combating internal cancers than we now have.

"The other merit is that this is a plan to enlist the general public and its money in an all-out fight against cancer, instead of leaving it to wealthy old gentlemen to bequeath money for cancer research to favored institutions.

"The race of wealthy old gentlemen is becoming largely extinct, because of crushing income and inheritance taxes. It is time for the general public to take up where the old gentlemen are having to leave off. Public endowment of research on specified diseases looks like an idea which should be carried on from cancer, infantile paralysis and tuberculosis to a lot of other widespread ailments which can still stand some research. As early candidates, we'd nominate heart trouble, arthritis, malaria, undulant fever, the several influenzas and the common cold."

MEDICAL GYNECOLOGY

By J. C. Janney. Phila., W. B. Saunders, 1945

Dr. Janney has written a very interesting book on office gynecology. He approaches the subject from the direction of the patient's complaint, and correlates this with actual pathology. He makes no effort to cover the entire field of gynecology, but covers very thoroughly the work that one usually does in office practice. I believe the book will be useful to the student and the general practitioner, who wishes to be brought up to date on office practice.

He has included most of the newer treatments, and hormone therapy in this book. He also goes into the usual methods of contraception; discusses their good points and also their weaknesses.

He also devotes a chapter to marital maladjustments, which shows he has wide experience in this field, and his advice is sound.

Dr. Janney has written a book which gives concise information on the problems that one meets in every day gynecological practice.

J. M. S.

PENICILLIN AND OTHER ANTIBIOTIC AGENTS

Wallace E. Herrell, Assistant Professor of Medicine, the Mayo Foundation. W. B. Saunders Co., Phila.

A cursory knowledge of its effect and of the indications for its use may be sufficient for the ordinary new drug which appears on the market, but such is not the case with an agent such as penicillin. Any physician who employs penicillin or any of the other antibiotic agents should have a thorough knowledge of these preparations if he is to use them to the best advantage.

This book is an attempt to furnish the busy physician with that knowledge and the result is highly satisfactory. We can recommend this book without reservation to any doctor who desires a concise and readable story of penicillin—its origin, its preparation, its properties, its antibacterial activity in vitro and in vivo, methods for administration and dosage, and its effect upon the various types of infection in man.

It is a book which can be read with enjoyment and studied with profit—and such a combination is all too rare in medical writing.

The Journal of the South Carolina Medical Association

JULY, 1945

VOL. XLI, NO. 7

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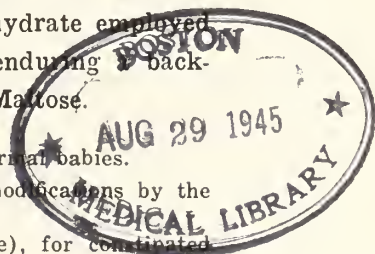
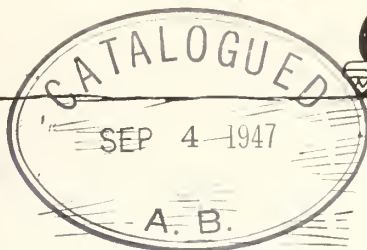
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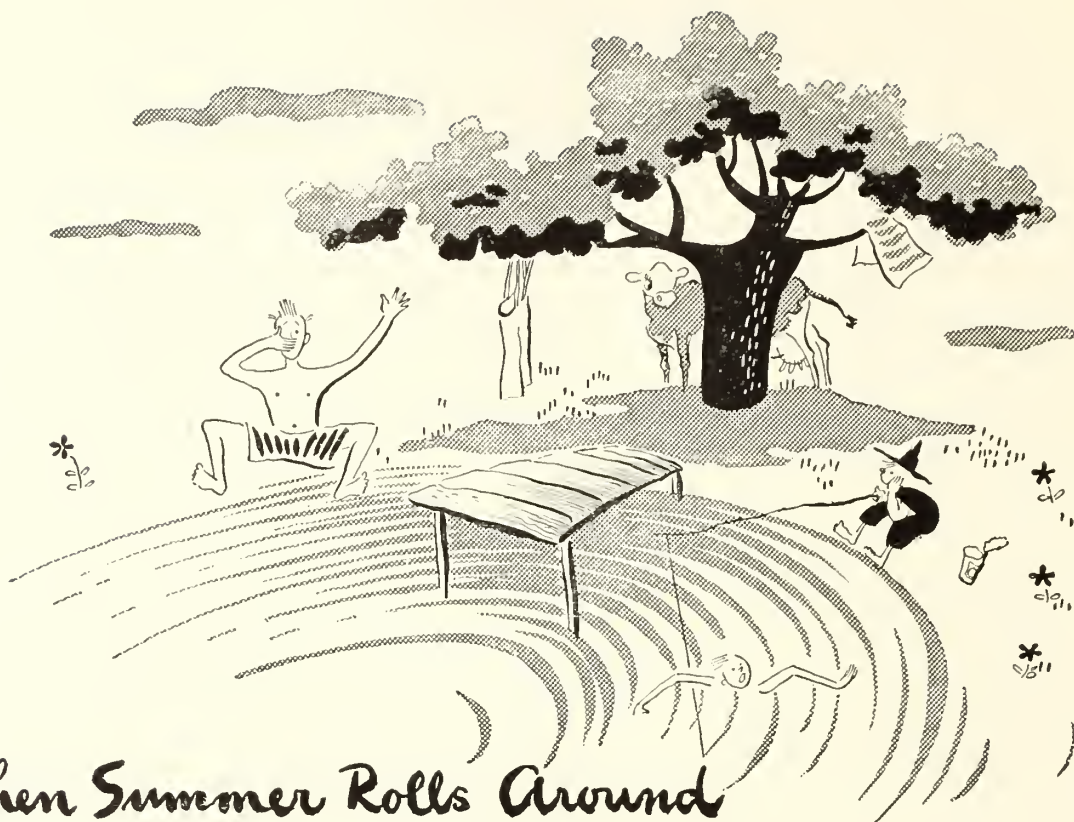
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1. Am. J. Dis. Child. 54:1227, 1937. 2. The Vitamins, Chicago, American Medical Assn., 1938, p. 524.

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NUMBER 7

Ambulatory Treatment of Varicose Veins

WM. H. PRIOLEAU, M.D., F.A. C.S., CHARLESTON, S. C.

In the past few years our ideas concerning the treatment of varicose veins have undergone some change and are now to some extent crystalized, thus promoting a discussion of the subject at this time. The ambulatory feature of the treatment is emphasized. It is of importance from several standpoints. First and foremost, it promotes activity of the deep venous return, thus reducing the likelihood of thrombosis taking place in the deep veins. In the same manner it tends to prevent unduly extensive thrombosis in the superficial venous system, with its disabling effect due to pain, swelling, induration and inflammatory fever, and at times ulceration. From a social and economic aspect the advantages are obvious, often making possible the treatment for some who could not well afford to be laid up. Finally and of particular importance at present, it does not require the use of hospital beds, which are better reserved for more urgent cases.

As to the etiology of varicose veins, there is a large hereditary factor. Pregnancy and certain occupations are often considered as true causes, but in reality they act only to precipitate or aggravate the underlying condition. While encountered at as young as eight years of age, they commonly are not noticed before the age of twenty, and generally are not productive of circulatory stasis until some years later, or even old age. In the well developed case the usual picture is that of dilated tortuous veins of the lower leg and often the thigh, in which the blood flow is sluggish or even retrograde due to incompetent valves and the abnormally enlarged venous bed. It is in such cases that we find increased pigmentation, dermatitis, edema and ulceration. On the other hand we are now seeing many cases before the venous stasis is of sufficient degree to be productive of symptoms. In some it appears as if the varicosities are

The Author:

Dr. Prioleau is a graduate of Johns Hopkins Medical School (Class of 1923) and is now Associate Professor of Surgery at the Medical College of the State of S. C.

limited to focal areas, however, it is our opinion that these focal areas are usually indicative of a more generalized condition, and accordingly the case should be treated as such.

Diagnosis is generally apparent from physical examination and symptoms. Tourniquet tests are of value in determining the points of retrograde flow from the deep circulation, and also the patency of the deep venous system, which must be assured before instituting obliterative treatment. For the latter purpose a pressure bandage may be applied as a therapeutic test.

Before obliterative treatment is started, it is important that edema and infection be reduced by pressure boots and other measures indicated. While not the time of choice, pregnancy is no contraindication to treatment, while it is often indicated at this time for the comfort of the patient.

The first definitive step in treatment is the interruption of the main communications between the deep and superficial venous systems by resection of the uppermost portion of the saphenous vein with its tributaries, and at times ligation of the saphenous trunk at lower levels, particularly at the knee; the sites determined by previous tourniquet tests. This removes to a great extent the abnormal head of pressure upon the poorly supported superficial venous system. At the same time in some cases it is well to inject the saphenous trunk in the thigh with a sclerosing solution, as this segment is difficult of injection later. It is preferable that there be induced at this time little or no thrombosis below the knee; to guard against this, the saphenous may be first

*From the Department of Surgery, Medical College of the State of South Carolina.

*Read before the Coastal Medical Society at Walterboro, S. C., April 19, 1945.

ligated at the knee level so as to prevent the downward flow of the sclerosing solution. As the extent of thrombosis resulting from ligation and injection is unpredictable, it is safer to be on the conservative side, so as to avoid disabling and at times alarming sequelae. The above operation entails considerable detailed work and requires an hour or longer for its proper performance. Local anesthesia is adequate. In the case of large varicosities a pressure bandage is applied from the toes to the knee, or above, so as to compress the veins and prevent massive thrombosis.

The patient leaves the hospital immediately after the operation and returns home even though he lives at a distance. He is instructed to be up and around, to avoid long standing, and while sitting to place the foot upon a chair. Only one leg is operated upon at a time, thus assisting in keeping the patient ambulatory. Subsequently, at intervals of from one to several weeks, remaining patent varicosities are injected. Monolate is generally used as it is of synthetic origin, thus reducing the possibility of allergic reaction. As it is impossible to predict the extent of thrombosis which will follow an injection, conservatism is practiced so as to avoid a disabling effect. As long as edema, ulceration, or dermatitis exist, a supportive bandage is used—generally an Unna's boot. In some cases of extensive varicosities it is advisable to keep the patient under observation more or less indefinitely, for the development of new varicosities, which should be treated by injection.

Ulcers of long standing may require excision and skin grafting, if they fail to heal after the obliteration

of the varicosities. In some cases of extensive varicosities, there has been noted the appearance of numerous small superficial varicosities in the foot, following the obliteration of varicosities in the leg and thigh. These are difficult to treat as their superficial covering and small size make them unsuitable for injection. Large varicose plexuses are better excised so as to avoid massive thrombosis which may require evacuation by incision. In spite of taking reasonable precautions, in some occasional case the thrombosis becomes unduly extensive with resultant swelling, inflammation, and febrile reaction. In such cases it appears likely that at times some of the deeper veins become involved with permanent damage to the venous return. With the treatment as above outlined, embolism is rare, and when occurring is not of serious consequence.

Treatment of varicose veins by injection alone is not to be recommended. In principle it is unsound, as it obliterates only superficial veins, and leaves untouched the head of pressure which soon results in dilatation of other veins. In such treatment there is some danger of massive embolism through the large opening at the sapheno-femoral junction.

The results of ambulatory treatment as herein described have been generally satisfactory. This form of treatment is of necessity spaced over a period of time, which has many advantages and few disadvantages. The treatment is carried out step by step and thus better regulated. To attempt to hasten the cure is unwise due to the inability to predict the extent of thrombosis which will take place following ligation, and injection of a sclerosing solution.

PRESIDENT'S MESSAGE FOR JULY

Under War restrictions I find it difficult to know how much or little we can do. This message is to urge the Council and members of various societies to feel free in offering me advice and comfort on perplexing problems.

For example: Should we plan a House of Delegates Session for October? If so, let's begin to plan through Washington.

Thos. Brockman

Aneurysm of Abdominal Aorta

Case Report

T. M. NORTHPROP, M.D., GREENVILLE, S. C.

Case Report:

Mrs. R. E. D. No. 2291

This 75-year-old white female was first seen about 6½ years ago. At this time she had what was thought to be a typical coronary occlusion with substernal pain, shortness of breath, weakness and shock. She was hospitalized and responded to treatment nicely. A mass about the size of an ordinary orange, was found in her abdomen. It was hard, smooth and fixed. It was in the midline one-half way between the umbilicus and xiphoid process. It pulsed but was not expansile. A bruit could be heard over it. She did not know it was present and had no symptoms from it. She was sent to an internist who worked her out thoroughly but could not locate the origin of the mass. An abdominal aneurysm was considered as the most likely diagnosis but a pancreatic cyst lying over the aorta and transmitting its pulsations was also considered as a very likely diagnosis.

Since that time her only complaints were with her bladder and kidneys. She had numerous attacks of pyelitis and cystitis. Her urine was always loaded with pus and blood and a trace to one plus albumin. Her symptoms were mainly frequency, dysuria, temperature elevation. These attacks responded well to mandelic acid therapy. Her blood pressure ran 190/100–210/110. She had no digestive symptoms at all.

Her last illness began with one of the typical bladder and kidney attacks. This time it did not clear right up on the usual treatment. She soon began running a temperature around 103 degrees and rapidly lost ground. She went into a urimic-type state and died a typical urimic death. A. N. P. N. was not obtained. Fluid intake was kept up to about 3,000 CC daily. Her output was pretty good even just before death but she lost sphincter control several days before this and her output could not be measured. Blood pressure during the first few days of her last illness was 170/100–180/110. This gradually dropped and was down around 130/100 and even lower a few days before she died.

Permission for an abdominal autopsy only was granted. The pathologist's report follows:

The body was that of a well developed, well nourished, white female, 75 years of age. The head was covered with an abundance of white hair. The eyelids were somewhat swollen and reddened and the conjunctivae were injected. The face was not otherwise remarkable. The neck was thin and contained no masses. The chest was symmetrical. The breasts were atrophic. The abdomen was flabby. The

The Author:

Dr. Northrop is a graduate of Vanderbilt University School of Medicine (1934) and practices medicine in Greenville.

genitalia were not remarkable. The extremities showed nothing of note.

Post mortem examination was limited to an exploration of the abdominal cavity. Section into the abdominal cavity showed the organs to maintain their usual relationship.

The stomach and intestines showed moderate gaseous distention and completely hid from view, the tumor, which had been palpated in the abdomen. Upon removal of the intestines this mass was seen to be present below the stomach, between the stomach and the colon. This mass was rounded, measuring 17 cm in diameter. On palpation it had doughy, crepitant texture resembling an ovarian dermoid. The duodenum was seen to course over the lateral surface of the mass and was intimately adherent to it. The pancreas lay along the diaphragmatic surface of the mass. After due dissection, the mass was seen to be a saccular aneurysm of the upper portion of the abdominal aorta. The aneurysm was seen to be thinned walled. The wall of the aorta being not more than half its normal thickness. The entire tumor mass was composed of a laminated, rubbery mass of old clotted blood. The aneurysm sprang entirely from the anterior wall of the aorta. The posterior aortic wall did not deviate from its usual situation and a sizeable channel larger than that of the intact aorta was found behind the blood clot and coursing along the posterior wall of the aorta. The bodies of the vertebra behind the aneurysm had undergone a pressure atrophy, so as to form a convex bed in it, where the aneurysm lay. The cartilage and bone composing the vertebra were nowhere roughened or eroded. Examination of the aorta showed it to be the seat of an extensive, ulcerative atherosclerosis.

The liver was of large size and was markedly congested. The gall bladder was very large and distended and contained a large green gall stone. The pancreas was small and atrophic. The spleen was small, slate colored and flabby. The adrenals were not remarkable.

Upon section of the kidneys a congenital absence of the right kidney was found. The left kidney was about ½ again larger than normal, but was of normal configuration. Its capsule stripped easily. The

cortex and medulla were of usual appearance and the vessels were not unduly prominent. The kidney pelvis and ureter were not remarkable. The urinary bladder was found to be markedly inflamed and moderately trabeculated. Two smooth and polypoid tumors were found projecting from the mucosa of the urinary bladder.

Upon section of the renal artery, this was found to enter the aorta in the midst of the aneurysm and firm adherent blood clot lay over the orifice of the renal artery in the aorta, obstructing its mouth almost completely.

The uterus, tubes and ovaries showed marked senile atrophy. The uterus was relaxed and retroverted.

PATHOLOGICAL FINDINGS:

Large Saccular Aneurysm of the Upper Abdominal Aorta.

Ulcerative Atherosclerosis of the Aorta.

Congenital Absence of the Right Kidney.

Occlusion of the Orifice of the Renal Artery in the Aorta.

Autopsy performed by Dr. L. E. Keasbey.

Bacteriological and Other Studies in the Public Aspects of Gonococcal Infection

HARRY BOATWRIGHT, M.D.

(Each year the members of the senior class of the Medical College of the State of South Carolina are required to prepare a graduation thesis. This paper of Dr. Boatwright's was awarded first place. We publish it to show the type of work of which students in our Medical College are capable of doing and also because we feel that there is valuable information contained therein.—Editor.)

PART I

There are numerous reasons why a paper on gonococcal infections is timely. Because of widespread incidence, serious complications, recent refinements in chemotherapy, and the too frequent mismanagement of the patient, it behooves every medical man to acquaint himself with recent progress in methods of diagnosis and criteria for cure. There is a profusion of writing on the subject in the current journals which tends to produce a disorganization of knowledge. There are a few useful points about which nothing is said directly and their content is merely suggested by the implication of various reports. The difficulty in detecting the presence of the gonococcus is much greater than with most bacteria and, at times, the gonococcus can remain as hidden as the virus, even with skillful application of all the best methods. At the present writing no selective media such as Loeffler's has been reported; there is no reliable serological test such as the Wassermann; and the skin tests have proved to be unsatisfactory. For diagnosis we must depend solely on a demonstration of the organism at the site of the lesion by smears and by careful culturing. There are many hazards in these procedures and it is imperative that certain precautions be taken.

I propose to present a summary of recent work bearing on etiology, laboratory procedures and diagnostic criteria. In addition some original work is presented. This latter is an endeavor to compare the effectiveness of chocolate agar and Peizer's Nile blue medium in so far as they inhibit the contaminating bacteria which tend to overgrow the gonococcus in

cultures taken from the female G-U tract. A study has also been made of various other media, containing inhibitory dyes to reduce or exclude the saprophytic species of bacteria from the female G-U tract which tend to overgrow the gonococcus on culture plates in inocula from suspicious cases of gonorrhea. A third objective is to present a helpful scheme in bacteriological differentiation through a superficial study of the more common species of bacteria found in the normal flora of the female G-U tract. An attempt is made to indicate those types of bacteria found frequently in the female G-U tract infected with the gonococcus, and to determine the ability of these saprophytic organisms to oxidize the O-R dye, para-aminodimethylaniline monohydrochloride.

ETIOLOGY

The gonococcus is a gram-negative diplococci commonly designated as a member of the pyogenic group. Intracellular and extracellular forms exist and, except for the meningococcus, this feature is diagnostic. There is a type which grows only in the presence of other bacteria or with a fresh extract obtained from liver, yeast, blood or similar substance. This component is thermolabile and is simple in composition. It is dialyzable, is alcohol-soluble, and is destroyed by autoclaving. Some types of gonococcus will grow well on practically all types of bacteriological media but more commonly they are very fastidious and require besides this thermolabile factor, a temperature between 35° and 36° C, and an increased CO₂ tension. Failure to take cognizance of these exacting and fastidious growth requirements may represent a very serious defect in diagnosis.

The work of Wolfgang A. Casper has shown that the gonococcus may undergo changes on transfer from the mucous membranes of infected individuals to culture media. He also maintains that these same serological, cultural, and morphological changes take place then transferred from one individual to another. Depending on differences in antigenic structure, the organisms in the same way as pneumococci

and streptococci, may be separated into different types. These types have distinctive carbohydrates of the polysaccharide nature.

Atkin has attempted classification on the basis of colony morphology. He designated the large papillae-bearing colonies from acute cases as type I. After incubation a small papillae variant was split off — this he called type II. Casper suggests that such division is not valid because he was able to grow a papillae-free colony by reculturing the papillae-free part of the colony. Casper prefers division into a mucoid, papillae-bearing strain and an R form similar to R forms of other species.

The change in cellular morphology will bear some emphasis; with cyclidlike regularity, varying morphological forms may be seen in degenerating cultures. Casper emphasizes that this degeneration does not mean death. All stages of transition between the diplococci and the blown-up monoforms may be seen. These gram-negative monoforms may be grown in pure culture in the presence of immune sera. This monoform type must be regarded as a specific infectious agent. It is frequently the only possible organism in chronic gonorrhea. Casper obtained this organism in pure culture from tubes and ovaries which showed no pathologic signs of acute infection (presumably they were chronic). The stability of the survival form is relative. Transition to the more virulent, rapid growing diploform may account for the exacerbations of acute symptoms in chronic cases and symptomless carriers. Casper presented another case in which the monoform was solely responsible for a male urethritis. On a previous check up the contact showed monoforms from the cervix and subsequently the same organism was obtained from the male urethra. A short time later a transition to the diploform was seen in the male. Further, the carbohydrate fermentation tests of the monoforms is identical with those of the diplococcus. As is true of the variants of streptococci and pneumococci, the agglutination titre of these survival forms is very low, i. e. seldom over 1:25. Professor John C. Torrey, of Cornell University, confirmed the work of Casper and identified his monoform as the gonococcus and also, in the same strain, observed the transition to the diplococcus on culture. The variant forms may be confused in ordinary examination with the nuclei of leucocytes. A double stain with Giemsa and comparison with the gram stain will differentiate the organism.

LABORATORY PROCEDURES

Dr. Charles M. Carpenter recently published a paper in outline form which is presented here with slight modification:

Collection of Specimens

A. General Directions

In acute cases samples may be taken from the cervix and urethra in the female. In chronic male cases specimens from prostatic secretions and urine

may also be submitted. Other sources of infectious material may be the conjunctiva, abscesses of Bartholin's glands, the Fallopian tubes, pelvic lesions, and rectal discharges. Cultures of blood and joint fluid occasionally reveal the gonococcus. Cultural examination should be attempted when there is the remotest suspicion in atypical meningitis. To avoid accidental infection to the conjunctiva, it is advisable to wear rubber gloves when obtaining the material. Cotton tipped applicators are suitable for most work. Separate swabs should be used for smear and culture. Asepsis is necessary only when material is taken from the spinal canal, joints, or an abscess.

B. Male

When pus is available at the meatus, inoculation is best directly on solid media. When no exudate is visible, the first 10-15 cc. of urine may be used. In chronic cases prostatic fluid should be cultured. The penile urethra is compressed by thumb and forefinger while the prostate is massaged in the usual manner. Following release, the fluid is allowed to flow in the test tube containing one c. c. of sterile broth. If exudate is scant, then insert swab into meatus after stripping urethra and place it in sterile broth. As a test for cure, a combined specimen of prostatic fluid and urine is preferable, i. e. 10-15 c. c. immediately after prostatic massage.

B. Female

If urethral meatus appears normal and no exudate is present, films and cultures from this area are not indicated. Specimens from the cervix are most important. A bivalve speculum without lubricant other than water or saline should be used. The cervix is gently compressed between blades and cleaned with dry cotton on dressing forceps. Then insert a small sterile swab, .5 to 1 cm., inside os while maintaining pressure on the cervix. In children a cotton swab or a glass female catheter may be used. The latter is preferable if a small amount of 0.9 N saline is introduced in the vagina and moved about to allow about 0.5 c. c. of vaginal secretion to flow in the catheter. Use one drop for the film and the remainder for culture. In specimens from the anorectal region asepsis should be carried out. Use an anoscope and obtain material from the mucosa adjacent to the terminal portion of the anal canal. In a fairly high percentage of females this area is infected.

D. Other Sites

1) Pus from the conjunctiva and from abscesses may be inoculated directly on to culture medium.

2) Blood culture may be carried by adding 5 ml to 100 ml of glucose ascitic fluid broth.

E. Precautions in handling specimens

The media should be brought to room temperature before inoculation. If the material is carried in an intermediate medium and planting is delayed, the temperature should be given 4° and 10° C to prevent overgrowth. Prompt inoculation gives best results.

F. Films

1) Spread exudate by rolling swab between thumb and index finger. This keeps pus cells intact and facilitates the intracellular criterion.

2) Thick films are undesirable and may be prevented by collection of but a small amount of exudate and rolling swab but once over the slide.

3) Air dry, fix with gentle heat, and label carefully.

4) The gram stain or Huckers is satisfactory.

5) Staph. and *E. coli* may be used for controls when technician is inexperienced.

6) An experienced observer should spend at least 5 minutes per slide.

7) The report should include extra-cellular gram negative diplococci if present in absence of the intracellular forms.*

G. Culture Media

Satisfactory media are chocolate agar, plasma agar, sheep or beef blood agar, starch casein hydrolysate agar, and horse plasma hemoglobin agar. Ten percent carbon dioxide and moisture should be provided to the vessel containing the inoculating media. Temperature should be maintained at 35°-36° C. The plates may be examined at the end of 24 hours. Direct inspection reveals, when positive, typically convex, transparent, 1-3 mm. in diameter colonies with undulating margins. The oxidase enzyme should be tested for with the appropriate indicator. When possible, and for all medico-legal cases, the organism should be obtained in pure culture and inoculated on the carbohydrate fermentation series.

Because of the great difficulty in carrying out this carbohydrate reaction, it is deemed sufficient in routine work where only treatment and diagnosis is in question to consider as positive those which have a typical colony form and which give the peroxidase reaction identified on a film with gram stain.

EVALUATION OF LABORATORY PROCEDURES

Mahoney, Van Slyke, Wolcott, Thayer and Nimelmann assimilated data over a period of 3 years on 2,429 women of the prostitute class. By this selection the data was intended to be relevant to chronic gonorrhea in women. It should not be construed otherwise. The technical aspects were in the hands of skilled and experienced workers. An intermediate

media of 2% proteose peptone broth was used for transport to the laboratory. Douglas chocolate agar used throughout the study.

Spreads were prepared from material taken from 664 patients. One hundred and forty were found by culture to harbor the gonococcus. The preparations were given to 3 microscopists; one reported 164 positive for gonococcus, another 60 and the third 44. These results were rendered by skilled and experienced workers and were interpreted by the investigators to be a method, per se, of questionable value.

As a result of single cultures from the cervix 21% revealed positive findings. Not infrequently a patient would present positive cultural and clinical evidence of g. c. infection then after a brief interval, without treatment, the cultures would become negative. Seventy-three patients with initial positive culture, cervical discharge, and without symptomatic adnexal involvement were selected. Material for culture was taken from each patient 2 to 3 times weekly and continued whenever possible for 3 to 4 months. The results were divisible into 3 groups. Type I, 46% remained positive throughout the period of study. Type II, 42% gradually or abruptly became culturally negative and remained so. Type III, 12% positive findings were followed by numerous negative cultures and sporadic positive cultures.

These findings are offered as explanation for the relatively low total positives for the group.

Evaluation of the influence of menstruation was attempted on the same group. In 189 menstrual periods, 92% of the data was unchanged during and for indefinite periods after flow ceased. In the remaining 8% about half became positive after being negative and the other 4% changed from positive to negative.

A second culture was carried out on 604 women. One sixth became positive on reculture and 25% of the positives became negative. The value of repeated examinations is obvious. A third series intended to compare the urethral and cervical sites revealed 3 out of 56 positive at the urethra and negative at the cervix. On only 23 of the 53 positive at the cervix could the gonococcus be found in the urethra. The clinical symptoms remained practically unchanged in the untreated cases regardless of the bacteriological findings.

REACTION TABLE

	Glucose	Lactose	Sucrose	Maltose	Levulose
N. Gonorrhoeae	Pos.	0	0	0	0
N. Intracellularis	Pos.	0	0	Pos.	0
N. Catarrhalis	Pos.	0	0	0	0
N. Sicca	Pos.	0	Pos.	Pos.	Pos.
N. Flava	Pos.	0	0	Pos.	Pos.

They conclude that "in the face of clinical and epidemiological evidence of chronic infection in women, it may be unwise to withhold treatment solely on the basis of negative culture results."

Trowbridge and McConkey say that culture of the gonococcus is a valuable diagnostic procedure but of dubious value when performed by a person not experienced in this field of bacteriology and when the clinician is unaware of the shortcomings of the procedure. Because, in divergence to Mahoney and coworkers who state, "Wholly asymptomatic infections (as in certain sulfa treated cases) are readily detected by the cultural method," Trowbridge shifted to Peizer's Medium as they were not able always to detect readily infection with chocolate agar. In an evaluation, 128 pairs of plates of Peizer's medium and chocolate agar were inoculated with the same material. For a rigorous test they used 44 smear negative patients. Their results:

	Chocolate Agar	Peizer's Medium
Very good	1	17
Good	5	18
Fair	17	6
Poor	12	2
Failure	9	1

These authors emphasize the importance of technique in obtaining material for culture. (See Laboratory Procedure in this paper, page 4). They also advocate direct inoculation of material on solid media.

CLINICAL DIAGNOSIS

Since in a few cases even with the most accurate laboratory methods and in a great majority of the patients these facilities are not available, I present a summary in outline form to serve as a basis for clinical diagnosis. It is largely from the paper by Adolph Jacoby, and concerns only the female regarding physical examination.

I. History.

A. History of exposure to a diseased or potentially diseased person.

B. History of sex partner having contracted the disease.

C. Presence or history of symptoms.

Eighty per cent of the patients present themselves with the chronic form of disease and the beginning symptoms will not be elicited except by careful questioning. Presenting symptoms may be: burning on urination, frequency and nocturia; vaginal discharge and often pain in back and/or lower abdomen.

II. Physical Examination.

A. Urethra and Skene's glands; separate labia and note redness, edema, or discharge around external urethra. Wipe with swab; insert index finger into vagina to compress at the level of the vesical neck the urethra. Maintaining pressure slide finger down. Smear and culture presenting exudate if any. Dis-

charge from these structures almost always indicates g. c.

In chronic infections the urethra becomes indurated, the Skene's glands on palpation are like elongated strands of catgut. The paraurethral glands may show secretion and this may be due to a reflex of the cervical secretion.

The orifices of Bartholin's glands lie in the lateral walls of the vagina between the labia minora and hymen. When inflammation exists, they are surrounded by a reddish areola known as Saenger's spots. The glands may be enlarged and palpable. In acute inflammation the overlying structures are reddened and swollen. After subsidence residua of the inflammation may be discovered by palpation with index finger inside vagina and thumb on the lateral preinnum. Inflammation in Bartholin's glands is practically always due to gonococcus.

The cervix varies from the acute phase with marked discharge, redness and edema of the portio to the chronic phase which may only present evidence of past erosion and habothian follicle cysts. These latter findings are not pathognomonic and can be caused by any bacterium.

STUDIES OF THE GENITO-URINARY TRACT FLORA IN SUSPECTED CASES OF GONORRHEA IN THE FEMALE, USING VARIOUS SELECTIVE MEDIA

I should like to thank Dr. Raymond M. Young, Ph.D., department of bacteriology of the Medical College of the State of South Carolina for his invaluable aid in the execution and planning of the laboratory work described in the following portion of this paper. I am also indebted to him for his patient and skillful teaching of the bare fundamentals associated with research of this kind.

METHODS

I. Preparation of Peizer's medium:

Peizer's Medium was prepared as devised by Peizer and Steffen and published in *Veneral Disease Information*, 1942, as "A Modification of the Horse Hemoglobin Agar for Primary Culture of the Gonococcus." The following steps are included in the preparation of this complex medium:

A. Agar base.

- (1) Distilled water—1,000 cc.
- (2) bacto-protose-peptone—No. 3—20 gm.
- (3) NaCl—5 gm.
- (4) agar—20 gm.

Dissolve by heating; autoclave 15 lbs., 20 minutes.

B. Stock solution.

- (1) sterile citrated horse blood plasma—300 cc.
- (2) sterile 15% K_2HPO_4 —90 cc.
- (3) sterile 5.3% packed blood cells in H_2O —470 cc.
- (4) sterile solution of 20% dextrose—9 cc.
- (5) sterile solution of 0.04% Nile Blue A—22cc.

C. Preparation of plates:

- (1) 300 cc. portions of the agar base, cooled to

60° C are added to 92 cc of the stock solution and mixed well.

(2) About 15-18 cc of the medium are added to a plate.

(3) The plates will keep 2-3 weeks in the refrigerator in air-tight containers.

(4) Plates must be free from all water of condensation before use; they should be warmed and dried after taking from the refrigerator.

2. Preparation of chocolate agar:

To 100 cc distilled water are added 2 gms. bacto-hemo-globin; this is dissolved over a water-bath, and autoclaved at 15 lbs. for 20 minutes.

To 100 cc distilled water, are added 9 gms. bacto-proteose No. 3 agar; this is dissolved over a water-bath, and autoclaved at 15 lbs. for 20 min.

After sterilizing, these materials are cooled at 55° C, mixed well and poured into petri dishes and allowed to harden. Before using, plates must be free from water of condensation.

3. Preparation of chocolate agar with nile blue and starch added.

To ordinary chocolate agar, melted and cooled at 55° C, is added aqueous solution of nile blue A to give a final concentration in the agar of 1/440,000.

Also to the medium is added a sterile solution of soluble starch to give a final concentration of 0.5%.

Vedder (*Jour. of Infectious Diseases*, 1915) found that addition of starch to the medium aids in the selection of gonococci.

4. Preparation of proteose No. 3 agar mediums containing various dyes: an agar base and stock solution were prepared as follows:

Agar Base:

distilled water—1,000 cc
agar—20 gm
NaCl—5 gm
proteose-peptone No. 3—20 gm.

Stock Solution:

sterile citrated horse blood plasma—300 cc
sterile 15% K_2HPO_4 —90 cc
sterile 5.3% packed blood cells in H_2O 470 cc
sterile 20% dextrose solution—9 cc
A. Bile brilliant green agar:
agar base—300 cc.
stock solution 92 cc.
bile No. 3 salts—3 gms.
neutral red—0.3 of 2.5% solution
brilliant green—0.3 cc of 3.3% solution

B. Malachite green agar:

agar base—300 cc.
stock solution—92 cc
malachite green—2 cc of 0.5% sol. (1/40,000 final).

C. Gentian violet agar:

agar base—300 cc.

stock solution—92 cc.

gentian violet—1 cc. of 0.5% sol. (1/80,000 final).

D. Nile blue A agar:

agar base—300 cc.
stock solution—92 cc.
Nile blue A—1 cc 0.5% sol. (1/80,000 final).

E. Plasma proteose No. 3 agar (control)

agar base—300 cc.
stock solution—92 cc.

5. Individuals included in the study.

Since the flora of the female G-U tract is much more complex of varied than that of the male, resulting in more difficult detection of the gonococcus, female subjects were employed in these studies. The subjects included persons attending the public health clinic in Charleston for examination either of their own accord or brought there as jail cases for routine examination. Some of the patients had received chemotherapy and were merely re-examined for effectiveness of treatment. Thus relative to degree of infection, there was great variation among the subjects employed, some individuals having no infection whatever, some showing suspicious evidence, a few having frank infection and still other chronic or chemically-treated cases showing questionable evidence of the organism being present in the G-U tract.

6. Method of taking smears for Gram staining and culture:

Both urethral and cervical smears on sterile cotton swabs were taken from the subjects with the aid of a speculum. For the Gram stain, the swab was gently "rolled" on the glass slide to avoid crushing or breaking up any pus cells that might be present carrying intracellular gonococci.

For the inoculation of plates, smears were taken from both the urethra and the cervix of the patients and placed in 0.5 cc of proteose-peptone No. 3 broth to allow an even distribution of the inoculum; then the same amount of inoculum was smeared over the various plates of medium employed, in order to study relative inhibition on the genital flora other than gonococci.

7. Incubation of plates:

The plates were placed in containers from which 1% of the air was replaced by CO_2 . The containers were incubated at 37° C for 48 hours.

8. Preparation of the dye-indicator:

The dye must be prepared immediately before use, for on standing a few minutes it oxidizes rapidly.

To 20 cc of distilled water is added 0.2 gm of the dye indicator, para-aminodimethylaniline monohydrochloride.

About 1-2 cc is flooded over the surface of the plate, being careful not to dislodge the colonies;

gonococcus colonies developed an intense purple color immediately on contact with the dye.

9. Detection of the different types of bacteria on the plates:

Identification was based on the morphological type of colony appearing and on other cultural characteristics. In addition Gram positive stained smears from the various type colonies were examined to learn Gram reaction and to obtain other information regarding the species relative to cell morphology, ar-

rangement of the cells, etc.

In some cases pure culture isolations were made and run through fermentation broths and other special mediums to identify the bacteria.

In a few instances the microscopic agglutination test was run to double check the presence of gonococcus colonies. Commercial diagnostic rabbit gonococcal antiserum was employed in these tests.

(To be concluded)

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DR. JOE TRAYWICK

"For gallantry in action against the enemy in the period from 6 November to 8 November 1944, near **, **. When his unit was assigned the mission of acting as Infantry in the vicinity of **, **, 6 November 1944, Captain Traywick, Battalion Surgeon, ****th Engineer Combat Battalion, voluntarily accompanied the forward elements of the Battalion into heavily-shelled forward positions. Finding that the routine procedure of establishing an aid station in a sheltered spot and having the wounded brought to him would delay the collection and treatment of casualties for some time, Captain Traywick elected to roam the fire-swept battlefield to treat men at the locations where they were wounded.

In the pursuit of his work, without sleep or rest, night and day, in cold, wet weather, Captain Traywick treated some sixty soldiers, thus greatly increasing their chances of living as a result of almost immediate attention. About 0300 hours on the morning of 8 November 1944, Captain Traywick was hit by enemy artillery fire. Despite painful wounds, he continued to treat others. About 1130 hours on the same day, he was killed by enemy artillery fire while giving aid to a wounded officer to whom he had gone. The heroic and gallant work of Captain Traywick throughout this period reflects great credit upon himself; it is in keeping with the highest traditions of the United States Army."

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THANK YOU, NEW YORK

"Medical statesmanship of a high order is reflected in a ten point program adopted recently by the South Carolina Medical Association," says new York Medicine, the official publication of the Medical Society of the County of New York. Under the heading, "Long Range Program in South Carolina," in its issue of May 20, the comment continues:

"The program is accurately described as 'a comprehensive, long range plan' and in formulating it, the Association states it was 'prompted by a feeling of social responsibility in the field of medical care and by the desire to take positive action in the promotion of continued, mutual good will between the profession and the public at large.'

"The plan is apparently designed to bring about cooperative action among all the groups in South Carolina who are interested in public welfare and health, to integrate all the present services and to exploit them to the utmost, avoiding the tendency to embark upon new and untried experiments."

After outlining the ten points, the article concludes:

"Surely this is a program worthy of a working partnership between medicine and its lay friends. It should also go far toward dispelling the misapprehension that physicians desire nothing more than to maintain the status quo."

This notice and sympathetic comment on the effort of our Association is appreciated.

THE DIRECTORY

Work is being started on our annual Directory which will be published in the fall. All members who have paid their dues for 1945 will be included in this list of names.

A word to the wise is sufficient.

CLEAR THINKING

One of the clearest thinkers and best writers in the newspaper field in South Carolina is the editor of the Marion Star. As proof of our contention we publish the following editorial which appeared recently.

HELP THE VOLUNTARY SYSTEM

It is interesting to note that most of the talk and agitation about so-called state medicine and socialized medicine, comes from sources that seek to curry public favor, and too often votes. The people are led to believe that they will get something for nothing under government control and subsidized medical and hospital plans.

The movement so vitally affects all the people, and it is so important that all individuals have proper medical attention, that the principles involved in plans to socialize medicine are apt to be overlooked. Fortunately, there has been resistance to the socializing process for medicine, because of the well-grounded fear, born of experience, that under bureaucratic control, mediocrity is promoted as individual initiative is stifled.

If the forces that seek to put government into the medical business, would, instead, help the medical profession perfect plans by which industries and individuals would be covered by voluntary programs for prepayment of medical and hospital bills on a monthly basis, they would be upholding the American tradition of private initiative saving the taxpayers countless millions of dollars, and what is most important, they would be encouraging rather than discouraging the expansion of medical service on a more sound basis than in any other manner.

Fortunately, the medical profession, industries and individuals have already worked out prepayment plans under which millions of people are now being cared for and millions more are being added as rapidly as they understand the advantages of such a system. They are acting as free citizens on a voluntary basis, and not under state compulsion with a new and arbitrary tax assessed against them whether or not they so desire it.

TWENTY-FIFTH ANNIVERSARY

This year marks the twenty-fifth anniversary of the Pediatric Seminar in Saluda, N. C.

No one can determine the amount of service this Seminar has rendered in its quarter of century of existence. Unique in its makeup and in its method of operation, it has been an outstanding example of post-graduate education for the man of medicine, and hundreds of physicians, scattered over the Southern states, will testify to its worth.

For two weeks each summer general practitioners from Virginia to Florida to Arkansas gather on "the hill." There for six hours or more each day they listen to lectures and clinics from outstanding pediatricians (and in recent years a few obstetricians). Time is allowed for general discussion and the answering of questions. The subjects treated are not those of the theorist or of the research scientist, but rather those which the busy physician meets in his every day practice. There is little wonder that many general practitioners return a second and a third time after their first experience.

Those who lecture do so because of their love of medicine and because of the opportunity which it affords for social fellowship with their colleagues. Because of this the list of the "faculty" includes the names of the outstanding pediatricians in the South. To be a member of the faculty is an honor which any physician might well cherish.

The faculty was formerly organized under the deanship of the late Dr. W. A. Mulherin of Augusta, Georgia. There was never a more devoted or loyal supporter of the Seminar. Following his death, Dr. Sam Ravenel of Greensboro, N. C., became Dean and has done a splendid job in this position. Dr. Ravenel's daily clinics during the first week of the Seminar are highlights of the course.

The originator, the general manager, and the motivating spirit of the Seminar has ever been and still is our own Dr. D. Lesesne Smith of Spartanburg. Without him there would never have been a Seminar. Others have helped materially, but his has been the biggest task and to him should go the greatest credit.

On this, the twenty-fifth anniversary, we extend our congratulations to the Dean, the faculty, and the members of the Seminar. Particularly, we congratulate you, Dr. Smith, on what you have done and what you are doing today in the field of medical education and medical fellowship. Your pioneer work has borne fruit, one hundred fold. We are proud to claim you as one of our own and we wish for you many more years of gainful service.

CANCER COMMISSION

By reason of shortage of time, which is universal on all people, the Cancer Commission has not been as active during the past year as usual. The cancer

control program of the State Board of Health, however, has been carried on in a satisfactory routine manner. The cancer control clinics have operated probably as well as present circumstances may allow, and these diagnostic clinics and hospital treatment have not been denied to any eligible persons.

For the coming year the State has appropriated \$50,000.00 to the cancer control program which is more than double that for last year. In addition the Federal Government pays the administrative expense, so that the whole State appropriation may be used in actual diagnosis and treatment for needy cases.

The campaign now being carried on by the Field Army of the American Cancer Society is better organized and should be much more productive than ever before in this State. Mrs. L. O. Mauldin, of Greenville, State Commander of the Field Army, and her district and county workers should have every possible support and encouragement from the medical profession.

Dr. G. S. T. Peebles and his assistants in the cancer division of the State Board of Health are doing a splendid job in the absence of the regular director, Dr. Clarence Gnyton, who has been on active military duty since the out-break of the war.

Respectfully submitted,

Kenneth M. Lynch, Chairman

BEING A COUNTRY DOCTOR IS A NICE THING

If he cracks a joke, he is rattled-brained.

If he doesn't, he is an old fogey.

If he studies and takes frequent refresher courses, he is one of those phoney specialists.

If he does not, then he has "gone up to seed."

If he is in his office, he should be attending his patients at their homes.

And if he is on the road, he should be in his office.

If he drives a dilapidated car, he must be a mighty sorry doctor.

But if he drives the newest expensive models, he is too darn rich.

If his patient dies, he should have taken her to the hospital.

But if the patient survives there was not much wrong with her anyway.

If he is single, he should get married because "I do not want any single doctor working on me."

But if he is married, "I will get another doctor because I do not like his wife."

If he is a general practitioner, he should be a specialist.

And if he is a specialist he has to wear a white coat, look wise at least and trace all ills to his particular field.

If he stays up all night on a labor case that extends into the next day, then "Ole Doc, just slipped off on a fishing trip."

If his patient gets a reaction from an injection of

anti-tetanus serum, then he sure must have tried to kill her.

If he fails to vaccinate the Smith child, then he has not done his duty.

And when he dies at an early age, the damned old fool just killed himself getting rich, working himself to death and should have known better.

Wade Temple, Lake View, S. C.

THE NEW WAGNER BILL

(Editorial Musings)

On May 24, 1945, a revised edition of the now famous Wagner-Murray-Dingell Bill was introduced into the U. S. Senate. (An analysis of this bill has been prepared by Mr. M. L. Meadors and will be found elsewhere on page 172.)

Should this bill be enacted into law it will affect vitally the course of medical history in this country. The system of medical practice as we know it will be gone. There are many who say that such a change—a revolution, if you will—is necessary to give the people of this country the medical care which they need. There are others, and their number is also great, who contend that such a change will not only retard the progress of medical care but that it will be detrimental to those two fundamental principles which have made America great—personal initiative and personal responsibility.

Being physicians, it is only natural that the members of our Association should be vitally interested in this proposed legislation. It not only concerns the life and work of every practitioner of medicine, but it also affects the life and welfare of the people of every community in the state.

The question might well be asked, "What attitude should each member of the Association adopt toward this new Wagner Bill and what positive action should be taken toward helping to have this bill adopted, amended, or rejected?"

Perhaps there are some who feel qualified to answer this question. We do not. We do not feel that we are in a position to tell the physicians of this state what they should think or do in this matter. All we dare do is suggest, and we herewith present specific suggestions for the consideration of our members.

Our first SUGGESTION is that we learn from past experience and avoid those illogical and unwholesome arguments which were used by many last year against the Wagner Bill.

The first argument to which we refer is "I am opposed to the Wagner Bill because I don't like it," or its first cousin, "I am opposed to the Wagner Bill because it will upset my personal way of life." Such a contention is futile in the long run—and yet there were many physicians who made this the theme song of their opposition. The personal wishes and desires of the few can never survive in a democratic state.

Another argument which we heard frequently was "There is no need for any change in medical practice as it exists today. Any one who really needs medical care can get it." This statement belies the facts. For example, Selective Service figures on rejectees do not by any means reflect the woeful physical condition of our men which some would have us believe, but they do show that something is wrong with a system of medicine which will allow so many many of our men to be under-par physically. Whether the enactment into law of the Wagner bill will change this condition is of course open to debate. But we should not let this confuse the issue in this specific argument. We should remember that it is one thing to deny that a certain drug will cure a certain ailment, but that it is another to deny that the ailment does not exist.

A third argument which we heard frequently raised by physicians and groups of physicians was, "We, the physicians, are the ones who know what is best in the field of medical care, and we will not tolerate any suggestions or proposals by those who have no medical training." Such an argument is the statement of an individual or group of individuals who claim omniscience—and there "ain't no such animal." To be sure, physicians have worked and lived in the field of medical care so long that their knowledge is great, and careful attention should be paid to what they suggest. But there are others who are vitally concerned—the industrialist, the labor leader, the farmer, the hospital administrator, the public health official, the social welfare worker, and above all the man who is sick and the man who pays the bill. Attention must be given to what these others have to say.

Another argument which we heard on many sides was, "I am opposed to the Wagner Bill because politicians are sponsoring it." Such an argument may be effective among those who are prone to be governed by slogans and not by reason, but it will bear little weight with those who think. Who else could sponsor such a measure or any other measure in our national Congress? It is strange how a member of Congress is labelled a statesman when he is working with us but immediately becomes a politician when he works against us.

A final argument which we wish to mention is the one, "I am opposed to the Wagner Bill because it will bring socialized medicine." Such a contention presupposes that socialized medicine is a distinct entity and that there is something inherently wrong with anything pertaining thereto. Such is not the case. We have heard innumerable discussions of one or more phases of socialized medicine and we have yet to hear a clear definition of the term. The care of the insane and of the tuberculous patient through the use of public funds is certainly socialized medicine, but we have heard no clamor on the part of any of the opponents of the Wagner Bill for return-

ing these patients to the care of private institutions. We recognize the vast difference between state supported hospitals for a small class of chronically ill patients and state supported medical care for the entire populace—but we still contend that each is a form of socialized medicine in a strict analysis of the term. To condemn socialized medicine per se, therefore, is to condemn our psychiatric and tubercular institutions along with the Wagner bill—and this we refuse to do. Physicians, scientifically trained, can ill afford to lose their sense of exactness and clarity of speech when they enter the broad field of social welfare and legislation, and they would do well to delete the phrase “socialized medicine” from their arguments.

SUGGESTION TWO

Our second suggestion is that no individual nor any small group is in a position at the present time to speak for our entire Association in this matter.

Physicians, by and large, are rugged individualists and they are accustomed to making their own decisions. Their scientific training and the nature of their work could result in nothing else. To attempt to speak for them without their consent is not only an act of foolishness but it invites resentment and antagonism. Give them the facts, make suggestions, and then let them make their own decision—such is the policy which we advise and such is the policy which we intend to pursue in our editorial columns.

It has been our observation that one reason the medical profession is not more united in its actions and in the front which it presents to the public is that too few have tried to speak for too many. That such a condition exists today is the fault of both the few and the many.

The few, duly elected or self-appointed as the case may be, have through study or reason or personal preference come to certain conclusions. Without adequately determining the opinions of the many, these conclusions of the few are presented to the public as the concerted thought of the entire group. Is there any wonder that some among the many are resentful and are prone to “kick the traces?”

On the other hand, there are those among the many who persist in being inarticulate. These men have definite ideas and opinions, but they keep them to themselves. The monthly meetings of the county medical societies and the pages of this Journal are available to these men for expressing themselves—but still they remain silent. If the old adage “silence gives consent” applies to these men, they have no one to blame but themselves and they should be the last to claim that they are being misrepresented by

those who attempt to speak for physicians in general.

SUGGESTION THREE

Our third suggestion is that each physician adopt the following course of action;

1. Study. Every physician should know just what the Wagner bill is and what it proposes to do. A careful perusal of the analysis of the bill (see page 172) will suffice for some while others will want to secure a copy of the bill from one of our representatives in Congress and read the original. In addition, each physician should study all available literature dealing with the various arguments for and against the measure. No physician would consider participating in a symposium on some medical subject without thorough preparatory study — why should he do less in the field of proposed social legislation?

2. Discussion. Having laid the groundwork through study, each physician would profit greatly by an exchange of ideas with others. He will soon find that consultation pays as well in things social and legislative as it does in things medical. His thought will be stimulated and crystallized as he listens to others talk and argues with them. Such discussions should not be confined to his colleagues alone but should be carried on with his patients and with those in other lines of work.

Each physician would do well to stimulate a general discussion of the subject among all the colleagues in his county. In this connection, we would suggest that each county medical society devote one of its next meetings to the Wagner bill—what it is, what it would mean to medical practice, wherein lies its strength and wherein its weakness.

3. United Effort. Personal study and mutual discussion will prepare the ground for united effort—and without united effort our work will be in vain.

It is true that we live in a small state and that our medical association is one of the smaller state organizations, but the force of nine hundred physicians if they are united and—if they are in earnest—can wield an influence which will be felt far beyond the confines of South Carolina.

Last year we instituted a Ten Point Program which is even now receiving recognition and commendation from distant parts of the country. Who can say that a similar program in each state, modified to suit local conditions, might not be the very means of warding off the revolution in medical care which is now being proposed. The united effort of every member of our Association might well become the yeast which will leaven the whole lump.

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* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60



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The Ten Point Program

M. L. MEADORS, EXECUTIVE DIRECTOR AND COUNSEL

THE 1945 WAGNER-MURRAY-DINGELL BILL AN ANALYSIS

The 1945 version of the Wagner-Murray-Dingell Bill was introduced in the United States Senate on May 24, 1945 by Senator Wagner and Senator Murray. A companion Bill was introduced on the same day in the House of Representatives by Mr. Dingell. The Bill (S. 1050) to be known as "Social Security Amendments of 1945," is broad and comprehensive, covering practically every phase of the social security system. It is divided into ten sections, each section dealing with a certain phase of the Social Security Program. It amends in various ways the present provisions for old age and retirement benefit payments, unemployment insurance, public health measures and related subjects. It includes, section 2, provision for extensive grants and loans for hospital and health center construction and for preliminary surveys for the purpose of ascertaining the needs along this line.

Section 9 provides for a National Social Insurance System. This is effected by amendment of the Social Security Act, as amended, by changing Title 2 of said act to read as provided in the Bill. This section, by which the comprehensive national social insurance system would be established, is divided into several parts, designated A to H inclusive. Part A, with which we are especially concerned, provides for the plan of Prepaid Personal Health Service Insurance. This is the part which affects more than any other the medical profession of the United States. This year there have been included also, in addition to provision for medical service benefits, similar arrangements with respect to dental service and home nursing. Also included are provisions for hospitalization and "laboratory" benefits. These are the principal provisions of Section 9:

I.—DEFINITIONS

(a) The term "personal health service benefits" includes general and special medical benefit, general and special dental benefit, home nursing, laboratory and hospitalization benefit.

(b) The term "general medical benefit" means services furnished by a legally qualified physician or by a group of such physicians, such as general or family practitioners.

(c) The term "special medical benefit" refers to services of a legally qualified physician who is a specialist or consultant or services of a group of such physicians qualified with respect to the class of service furnished.

(d) The terms "general dental benefit" and "special dental benefit" have the same meaning with respect to dental services as do the foregoing terms respectively in reference to those of the medical profession.

(e) "Home nursing benefit" means nursing care of the sick furnished in the home by (1) a registered professional nurse or (2) a practical nurse who is legally qualified.

(f) "Laboratory benefit" means such necessary laboratory or related services, supplies or commodities as the Surgeon General may determine, including chemical, bacteriological, pathological, diagnostic and therapeutic X-ray, ophthalmic services and eyeglasses and related supplies.

(g) "Hospitalization benefit" means an amount, as determined by the Surgeon General after consultation with the Advisory Council, not less than \$3.00 and not more than \$7.00 for each day of hospitalization not in excess of 30 days; not less than \$1.50, nor more than \$4.50 for each day of hospitalization in excess of 30 days and not less than \$1.50 and not more than \$3.50 per day for each day of care in an institution for the care of the chronic sick. In lieu of such compensation, the Surgeon General is authorized to enter into contracts with participating hospitals on a cost-per-day basis within the above limits.

(h) "Participating hospitals" are institutions providing all necessary and customary hospital services and found by the Surgeon General to be qualified according to the requirements set out in the Bill.

II.—PERSONS ENTITLED TO PERSONAL HEALTH SERVICE BENEFITS

Every individual, and every dependent of an individual, who is "currently insured" as defined elsewhere in the Social Security Act, and who has been determined by the Social Security Board eligible for benefits, is entitled to receive personal health service benefits. Also entitled are all individuals who are eligible for and entitled to old age, retirement, survivors and extended disability insurance benefits, provided for under Part C of the section.

In order to be "currently insured" and therefore eligible, one must have been paid wages of not less than \$150.00 during the first four of the six completed calendar quarters immediately preceding the first day of the benefit year; or must have been employed and insured under the Social Security Act for not less than six quarters out of the first twelve of the fourteen completed quarters immediately preceding the first day of the benefit year.

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III.—PERSONS AUTHORIZED TO FURNISH SERVICES

(a) Any physician, dentist or nurse legally qualified by a State to furnish any of the services included as personal health service benefits will be qualified to furnish such services under the terms of the Bill. This provision extends to any group of physicians, dentists or nurses or combinations thereof whose members are similarly qualified.

(b) Those physicians and dentists who are qualified to render specialist or consultant services as determined by the Surgeon General in accordance with general standards previously prescribed by him, would be authorized to render specialist or consultant services as benefits under the Bill. In establishing the general standards for such services, the Surgeon General is required to consult with the Advisory Council and to utilize standards and certifications developed by competent professional agencies and to take into account the personal resources and needs of regions and local areas. The specialist or consultant services would be available only upon advice of a general or family practitioner or an attending specialist or consultant or when requested by an individual entitled thereto, and approved by a medical administrative officer appointed by the Surgeon General.

Home nursing benefits would be available only upon the advice of a legally qualified attending physician or when requested by an individual entitled thereto and approved by a medical officer designated by the Surgeon General.

(c) Hospitalization benefits would be furnished by those participating hospitals included upon a list of such institutions to be published by the Surgeon General. The right of institutions to be included on such list is to be determined according to general standards previously prescribed by the Surgeon General after consultation with the Advisory Council; and he is directed to make findings of fact and decisions as to the status of any institution with reference to such standards.

In this connection it is specifically provided that the Surgeon General shall exercise no supervision or control over a hospital which is not Government owned or operated, and that no requirement for participation shall prescribe the hospital's administration, personnel or operation.

(d) Laboratory benefits would be furnished by legally qualified practitioners other than physicians and include certain services and appliances prescribed by a physician or other legally qualified practitioner. When such services or supplies are provided to a hospitalized patient or by a physician or dentist incidental to services furnished by them as benefits, payment for such laboratory benefits will be included in payments for hospitalization or the other services respectively.

Every individual entitled to general medical or

general dental benefits is permitted to select from those qualified and designated as provided in the Bill the ones from whom he shall receive such benefits, subject to consent of the practitioner selected and such selection may be made through a representative of the individual and may be changed. A list of the names of the medical and dental practitioners and groups of the same who have agreed to furnish services shall be published and made known in each local area by the Surgeon General, these lists to include general or family practitioners and qualified specialists and consultants, the latter to be identified with the class or classes of services for which each is qualified.

IV.—HOW PAYMENT FOR SERVICES TO BE MADE

(a) The Bill provides that payment for the services of general and family practitioners or general dental practitioners shall be made (1) on the basis of fees-for-services, according to a schedule; (2) on a per capita basis; (3) on a salary basis, whole or part-time or (4) on a combination or modification of the other plans, as approved by the Surgeon General. The method of the four enumerated to be used is to be determined in each local area as the majority of the general medical and family practitioners or of the general dental practitioners shall elect; and where certain of the practitioners in a given area do not select the method approved by the majority, the Surgeon General is authorized to make payment to them according to one of the other methods where he determines that such action will contribute to carrying out the purposes of the section. It is provided that the Surgeon General shall not be prohibited from negotiating agreements or cooperative working arrangements to utilize inclusive services of hospitals and their staffs or from entering into contracts for such inclusive services.

(b) Payment to qualified and designated specialists and consultants for their services may include payments on a salary, per session, fee-for-service, per capita or other basis as the Surgeon General and the specialists and consultants may agree.

It is provided that payments for all of the services, and this applies to the services of practitioners, specialists or nurses, may be either nationally uniform or adapted to meet local conditions. (This provision apparently is in conflict with the other referred to above in respect to payments for services to general practitioners—that the same shall be based upon the decision of the majority in each local area.) It is also provided that the payments shall be adequate in terms of annual income or its equivalent and by reference to the annual income customarily received among physicians, dentists or nurses, having regard for age, specialization and type of community. It is also provided that payments shall be commensurate with the skill, experience and responsibility involved.



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(c) The Surgeon General is authorized, in the interest of maintenance of high standards of quality, to prescribe maximum limits to the number of potential beneficiaries for whom a practitioner or group of practitioners may undertake to furnish services. These limits may be nationally uniform or adapted to take account of relevant factors.

With respect to the individuals who, after due notice, fail to select a general or family practitioner or who have been refused by the practitioner selected, the Surgeon General is authorized to make per capita payments on a pro rata basis among the practitioners of the local area involved. In each local area the provision of general medical and dental benefits for all individuals entitled to the same shall be a collective responsibility of all the qualified practitioners in each branch who have undertaken to furnish such benefits.

V.—ADMINISTRATION

The administration of the system is placed in the hands of the Surgeon General of the Public Health Service who shall perform his duties under the supervision and direction of the Federal Security Administrator and after consultations with the Advisory Council as to questions of general policy and administration. Also he shall have the duty, in consultation with the Social Security Board, of studying and making recommendations as to the most effective methods of providing personal health service benefits through social insurance and otherwise, as to legislation, matters of administrative policy, etc.

The Surgeon General is directed to take all necessary steps and after consultation with the Advisory Council, to negotiate agreements or working arrangements with appropriate agencies, Government or otherwise, private persons or groups and combinations, to utilize their services and facilities in furnishing the benefits provided for. He is authorized to delegate to any officer or employee of the Public Health Service or any Government or local cooperating agency such of his powers and duties as he may consider necessary and proper. After consultation with the Board and the Council and with the approval of the Federal Security Administrator, he shall prescribe and publish rules and regulations and require such records and reports as may be necessary. The Surgeon General shall notify the Managing Trustee of obligations incurred and certify disbursements from the Trust Fund to meet the same. He shall appoint local area committees to aid in administration, these to include representatives of persons entitled to receive services as benefits, practitioners, groups of practitioners, institutions and agencies furnishing services, and others. Such committees shall be consulted at frequent intervals and kept informed as to availability of benefits and are authorized to make reports with recommendations to the local area officers or to the Surgeon General.

(a) The National Advisory Medical Policy Council, established under this section, would consist of the

Surgeon General as Chairman and 16 members appointed by him with the approval of the Federal Security Administrator. The 16 members would be selected from panels of names submitted by professional and other agencies concerned with medical, dental and nursing services, education, and with the operation of hospitals and laboratories and from among others informed on the need for or provision of the services indicated. The membership of the Council would include medical and other professional representatives and public representatives in such proportions as are likely to provide fair representation to the principal interested groups; to meet not less than twice a year and whenever at least 4 members request a meeting. Each member would hold office for 4 years with expiration of their terms staggered. They would be paid at the rate of \$25 per day while attending meetings or to official business and traveling, in addition to travel expenses.

The Council would advise the Surgeon General with reference to general policy and administration, professional standards, designation of specialists and consultants, methods of encouraging the attainment of high standards in professional and public health work, standards for participating hospitals, methods of paying for personal health service benefits, their quality and adequacy, policy and procedures for determination of disability and grants-in-aid for professional education and research. The Council is authorized to function through committees or commissions.

(b) A hospital not included on the list of approved participating hospitals or which has been removed therefrom for cause is authorized to petition the Surgeon General, whereupon a hearing may be held at which evidence would be offered as to the hospital's right to be included on the list.

(c) The Surgeon General is authorized to establish Appeal bodies to hear complaints of interested parties, members of the public, practitioners or hospitals, and to take such steps as may be appropriate to remedy the grounds for complaint. It is provided that where disputes involve questions of professional conduct, the hearing body shall contain disinterested professional representation and shall consist exclusively of such where the only questions involved concern professional practice or conduct. Such powers and duties conferred on the Social Security Board with respect to disability, unemployment and old age insurance under the Act are vested in the Surgeon General with respect to this part involving personal health service.

(d) The benefits provided may be extended to "non-insured" individuals in return for equitable payments to the Trust Fund in accordance with agreements and working arrangements entered into by the Surgeon General with various public agencies. This is designed obviously to provide for coverage of Government employees and other limited groups of

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employees not now reached by the provisions of the Social Security Act.

(e) After consultation with the Advisory Council and with the approval of the Administrator, the Surgeon General may:

(1) Require every individual entitled to the benefits hereunder to pay a fee with respect to the first service or with respect to each service in a period of sickness or course of treatment. The payment of such fees may also be limited to certain classes of service as, for instance, home calls, office visits, etc. This provision is expressly for the purpose of preventing or reducing abuses in connection with the procuring of benefits.

(2) Restrict the content of dental or home nursing benefits, having regard in this connection for the adequacy of available personnel.

(3) Increase the maximum number of days for which an individual may be entitled to hospitalization during any one year beyond 60 days which otherwise is fixed as the maximum. Such action may be taken when the Surgeon General finds that moneys in the separate account are adequate.

(4) Limit for any calendar year or part thereof the cost of laboratory benefits to be borne by payments from the separate account established for that purpose.

(f) Specific limitations on the time for filing application for hospitalization benefits are provided. The Surgeon General and the Social Security Board jointly are charged with the duty of studying and making recommendations as to methods of providing related benefits not provided for in the Act, expected costs of same and methods of payment; also as to needed services and facilities for the care of the chronic sick, physically or mentally affected, and methods of prevention of such ailments.

(g) The benefits provided under this part of the Bill are not to be applicable with respect to any injury, disability or disease, treatment or other benefit in connection with which would be compensable under a workmen's compensation plan of the United States or any State.

(h) It is provided that the methods of administration shall insure prompt and efficient care of individuals, promote personal relationships between physician and patient, provide professional and financial incentives for the advancement of practitioners and encourage high standards in the quality of services through the adequacy of payments, assistance in opportunities for study, use of facilities, etc. They shall also be designed to aid in the prevention of disease, disability and premature death.

(i) The Surgeon General is required to make a full report to Congress at the beginning of each session, including a record of consultations with the Advisory Council and the latter's recommendations.

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(j) Finally, appropriation is authorized for the fiscal year ending June 30, 1946 and for each year thereafter of a sum sufficient for all necessary expenses, and appointment is authorized in the Public Health Service of such personnel and in such grades as may be necessary without regard to other limitations in the Public Health Service Act.

VI.—GRANTS-IN-AID FOR PROFESSIONAL EDUCATION

The Surgeon General is authorized to administer grants-in-aid to nonprofit institutions and agencies engaged in research or professional education where application has been made therefor and the Surgeon General finds with the advice of the Council and after consultation with other federal agencies that such aid is justified by the probable results to be accomplished. During the 5-year period beginning January 1, 1946, it is directed that preference be given such grants with respect to projects to aid servicemen seeking post graduate education as medical or dental practitioners and in related services. An amount equal to 1% of the total sum expended for benefits exclusive of unemployment insurance benefits, or 2% of the amount expended for benefits under Part A after the first year, is provided for the purpose of making such grants-in-aid.

VII.—EVIDENCE, PROCEDURE AND JUDICIAL REVIEW

This subject is covered under Part H of Section 9 of the Bill and as set forth therein applies to the other phases of the National Social Insurance System as well as to that dealing with personal health service benefits. It will be recalled that the Surgeon General, elsewhere in the Bill, is given with respect to administration of personal health service benefits the authority vested in the Social Security Board in respect to other benefits. Therefore, for the convenience of the reader, the references in this part of the Bill to the Social Security Board have been changed in the following observations to read "the Surgeon General."

(a) He is directed to: (1) make rules and regulations, establish procedures and methods of proof as to rights of benefits; (2) make findings of fact and thereafter if requested hold hearings and, on basis of evidence, affirm, modify or reverse his previous decision; (3) on his own motion, hold hearings and conduct investigations as he may deem necessary; (4) issue subpoenas and compel attendance of witnesses from any place in the United States or its possessions. In case of refusal to comply, the District Court is authorized to issue an order requiring same, non-compliance being punishable as contempt.

(b) The same section provides that the decisions of the Surgeon General shall be reviewable by civil action in the District Court of the United States, commenced not more than 60 days after notice of such final decision, said action to be brought in the district in which the plaintiff resides. In such action the

Surgeon General's findings of fact, if supported by substantial evidence, shall be conclusive; the court, on motion of the Surgeon General before his answer is filed, shall remand the case for further action by the Surgeon General and may at any time for cause order the taking of additional evidence, in which event the Surgeon General may modify or affirm findings of fact or decision or both and file same with the Court. The judgment of the Court shall be subject to review the same as in other civil actions.

Upon final decision of the Surgeon General or the Court, payment is to be made to the person entitled to the same, by the Managing Trustee, except that where review of the Surgeon General's decision is or may be sought as provided herein, such payment may be withheld pending such review.

(c) Under this section also the Surgeon General is authorized to make payment where the interest of an applicant would be served thereby, without respect to his legal competency or incompetency. The Surgeon General is authorized to delegate to any member, officer or employee (presumably, of the Public Health Service) any of the powers conferred upon him by this section and to be represented by his own attorneys in Court. Other provisions with respect to certain administrative details of no particular importance are also included.

The remainder of Section 9 deals with other phases of the National Social Insurance System, generally by amendment of the existing provisions of the National Security Act. It is not concerned with services in the form of medical care or hospital treatment. The principal divisions will be referred to very briefly:

Part B deals with unemployment insurance and payments for temporary disability, increasing to some extent the amounts payable under existing law.

Part C amends the provisions of the present law in reference to retirement and old age insurance, survivors and extended disability benefit payments.

Part D makes provision for the National Social Insurance Trust Fund, referred to throughout the Bill, including Part A of Section 9, as the Trust Fund. It is provided that this Fund shall consist of the assets held by the Secretary of the Treasury for the Federal old age and survivors insurance Trust Fund on January 1, 1946, contributions collected under the National Social Insurance Contributions Act, and such other amounts as may be paid or belong to the Trust Fund by virtue of any other provision of law. There is authorized to be appropriated to the Trust Fund such additional sums as may be required to finance the benefits and payments of the Social Insurance System.

The Board of Trustees of the said Trust Fund is created, to consist of the Secretary of the Treasury, the Secretary of Labor and the Chairman of the Social Security Board, the Secretary of the Treasury being designated as the Managing Trustee. The duties and responsibilities of the Board and of the Managing Trustee are fully set forth in this Part.

Part E makes provision for the allowance of credit for military service to the extent of \$160 to each serviceman as remuneration for employment for each calendar month or any part of the same, of active military or naval service after September 7, 1939. The term "serviceman" includes men and women. Provision is made for retroactive payment of the benefits.

Part F consists of definitions and provisions with respect to insurance coverage and eligibility for benefits under the National Social Insurance System.

Part G prescribes the Social Insurance contributions to be made by both employers and employees.

Under the provisions of this Part, every employer and every employee would pay a contribution equal to 4% of the wages paid or received, respectively, after December 31, 1945 with respect to employment after such date, and every self-employed individual would pay 5% of the market value of his services rendered as a self-employed individual after Decem-

ber 31, 1945 with respect to services after such date, up to the amount of \$3600 per year.

Other provision is made for the payment of a lesser proportion of wages by employees under special conditions.

Authorization is made for appropriation from time to time to the Trust Fund of amounts equal to the contributions in civil employment, in respect to the credits provided under Part E of \$160 per month for military service.

The Social Security Board is charged with the duty of collecting the contributions provided for, and other administrative and technical provisions are included.

Part II—In addition to the provisions with respect to Evidence, Procedure and Judicial Review, dealt with above, this Part includes a number of other general provisions having reference chiefly to the administration of the phases of the Social Insurance System, which are not concerned with personal health benefits.

CORRESPONDENCE

May 31, 1945

Julian P. Price, M.D., Editor
Journal of the South Carolina Medical Assn.
Florence, South Carolina

Dear Dr. Price:

On Thursday, May 24, I introduced with Senator Murray a bill, S. 1050, entitled: "The Social Security Amendments of 1945." The bill provides for "the national security, health and public welfare." Representative Dingell of Michigan introduced a companion bill (H. R. 3293) in the House at the same time.

I am forwarding the bill itself, and a copy of my speech in the Senate for your information and use.

I particularly invite your earnest study of the provisions of the bill relating to health. There is absolutely no intention on the part of the authors to "socialize" medicine, nor does the bill do so. We are opposed to socialized medicine or to State medicine. The health insurance provisions of the bill are intended to provide a method of paying medical costs in advance and in small convenient amounts.

During the formulation of this bill, we have bene-

fited greatly from the constructive advice and suggestions of practicing physicians, and of physicians in clinical and teaching positions. Their constructive suggestions have resulted in changes in the bill which we presented in the last Congress. Undoubtedly other changes will be made before the bill is enacted into law. We wish to have it known that we invite constructive suggestions from the medical profession.

In addition, members of the medical profession will be given full opportunity to voice their opinions in open hearings when the bill is considered in Committee.

I hope that you will print this letter in your Journal and that you will join me in urging the medical profession to undertake an earnest study of the actual provisions of the bill. In this way you can help immeasurably in avoiding misunderstanding and misinterpretation of the legislation and in stimulating physicians and medical and hospital organizations to come forward with constructive suggestions and advice.

Sincerely yours,
ROBERT F. WAGNER

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SOUTH CAROLINIANA

J. I. WARING, M.D., CHARLESTON, S. C.

Authors are earnestly requested to furnish this department with reprints or abstracts or both, to be sent to 82 Rutledge Ave., Charleston 6, S. C.

ALLISON, J. R. (Columbia): The relation of hydrochloric acid and vitamin B complex deficiency in certain skin diseases. (South. Med. J. 38:235-241, April, 1945)

Dr. Allison finds that persons with skin diseases due to or associated with deficiency of the vitamin-B complex have a deficiency of gastric hydrochloric acid, and that best results are secured by giving both of these substances.

BUNCH, G. H. (Columbia): Mucoid disease of the appendix. (Ann. Surg. 121:704-709, May, 1945)

A rather rare disease due to chronic localized obstruction, giving rise to mucocele and perhaps eventually to such a curious condition as "jelly-belly." Four cases are reported.

LASSEK, A. M. (Charleston): The human pyramidal tract: X. The Babinski sign and destruction of the pyramidal tract. (Arch. Neurol. & Psy. 52:484-494, Dec., 1944)

In a full and heavily documented article Dr. Lassek points out that the Sign of Babinski can be elicited in persons with no loss of pyramidal tract fibers, and in a few "normal" people. Drugs, hypoglycemia and other factors may produce the sign temporarily. The productive mechanism is of a capricious nature.

LAUB, G. R. (Columbia): Ranula. (Arch. Otolaryngol. 41:300-302, April, 1945)

A cystic tumor of unknown cause which should be removed through the mucous membrane of the mouth. Report of removal of such a tumor about 2 inches in diameter.

MacINNIS, K. B. (Columbia): Allergy the stepchild of medicine. (South. Med. & Surg. 107:109, March, 1945)

The writer believes that this great, big, overstuffed stepchild requires a most compendious scientific knowledge for his control. The prospect, like allergy, overwhelms us. Sometimes we think that as a "major branch," it should be broken from the medical family tree and used to whip itself into a proper shape.

MOORE, A. T. (Columbia): Fractures of the hip joint. (South. Med. & Surg. 107:16-17, Jan., 1945)

A method of treatment involving multiple nailing

or blade-plate fixation is reported. 300 cases are analyzed.

PRIOLEAU, W. H. (Charleston): Extensive varicosities of the leg originating from the gluteal vein. (Surgery 17:135-137, Jan., 1945)

Report of an unusual source of varicosities treated successfully surgically.

SMITHY, H. G. (Charleston): Complicating factors in the surgical management of varicose veins. (Surgery 17:590-605, April, 1945)

The author discusses anatomic variations, thrombophlebitis, cellulitis and other conditions making successful surgery difficult. Interruption of sympathetic nerve impulses is helpful. A severe reaction to sodium morrhuate is reported.

Ibid. Mixed malignancy of the breast. (Surgery 16:854-864, Dec., 1944)

The presence of two different types of neoplastic tissue in the same organ is rare. The author summarizes reported cases and describes an instance of mixed sarcoma and adenocarcinoma of the breast of a ten year old Negro girl. Surgery and radiation appear to have effected a cure up to nearly four years later. The case appears to be unique.

STUBBINGS, S. G., Jr.: See White, J. W.

WESTON, Wm. Jr. (Columbia): Rheumatic fever. (South. Med. J. 38:189-194, March, 1945)

Dr. Weston notes that rheumatic fever is more common in the South than is usually believed. He cites the factors which bear on the development of the disease, and summarizes a series of 30 cases.

WHITE, J. W. (Greenville): Growth arrest for equalizing leg lengths, by J. W. White and S. G. Stubbings, Jr. (J. A. M. A. 126:1146-1149, Dec. 30, 1944)

The authors present their experiences with a simple surgical technique, and offer a scheme of calculation for the procedure.

ZIMMERMAN, S. L. (Columbia): Pulmonary hypertensive heart disease. (South. Med. J. 38:33-38, Jan., 1945)

The author discusses failure of the right ventricle from various causes, and indicates the value of electrocardiographic studies. Expectations of results of treatment are somewhat pessimistic.

BOOK REVIEWS

A TEXTBOOK OF OPHTHALMOLOGY

Third Edition, Revised, by Sanford R. Gifford, M.D.
Publishers W. B. Saunders Co., Philadelphia, Pa.,
1945

Designed in 1938 as a book to compress in a limited space of one small volume the more practical and essential facts of ophthalmology for the general practitioner and medical student, this textbook has undergone its second revision, in its attempt to keep pace with ever changing modern concepts. New sections have been added to include further discussion of ptosis, contact glasses, cyclodiathermy, and epidemic keratoconjunctivitis. There are 215 illustrations; 13 color plates; and, four explanatory charts included in the appendix which states the appraisal of loss of visual efficiency as the standard method approved by the American Medical Association. The text, itself, of necessity, must be brief but it is complete and certainly adequate.

G. A. S.

PERIPHERAL NERVE INJURIES

Principles of Diagnosis; Webb Haymaker and Barnes Woodhall. W. B. Saunders Co., Philadelphia, 1945.
\$4.50.

This book is the most complete manual on the diagnosis of peripheral nerve injuries yet published. The 225 illustrations include photographs of patients with typical lesions and simplified anatomical sketches of great clarity. These were collected largely through the Medical Illustrations Service of the Army Institute of Pathology. Tests for the function of all important peripheral nerves are clearly described. The pathologic changes in injured nerves are not emphasized. Details of treatment are not included in the scope of this book. However, some reference to therapy might increase its value to the average practitioner. It is a volume that should be on the desk of every physician who handles peripheral nerve injuries.

F. E. K.

A MANUAL OF TROPICAL MEDICINE

Mackie, Col. T. T., Hunter, Major G. W., and Worth, Captain C. B.

Prepared under the auspices of the Division of Medical Sciences of the National Research Council, Phila.,
W. B. Saunders, 1945

This volume does not pretend to be exhaustive, but provides in small compass a large amount of brief, handy information. South Carolina normally includes a sufficiently large number of tropical diseases to make this book a very useful desk manual for the practitioner in various lines, and returning members of the armed forces will probably bring back varieties of disease strange to us. Some of the information is heretofore unpublished. A section on laboratory methods is included. The book is well illustrated and indexed and of a size fit for comfortable reading.

J. I. W.

MODERN CLINICAL SYPHILOLOGY; DIAGNOSIS, TREATMENT, CASE STUDY

Stokes, J. H., Beerman, H., and Ingraham, N. R.
3rd ed. Phila., W. B. Saunders, 1944

In reviewing this text one cannot help but be impressed and grateful to the authors for so complete and organized a presentation of a subject so prominent before the medical profession today.

Differential diagnoses are given in detail and the various systems of the body are taken up separately. Many helpful illustrations and summary sheets are presented in the unique manner of the authors and make possible quick and impressive references.

This text also treats the subjects from the standpoint of the Armed Services and Public Health.

The modern conception of treatment is so thoroughly covered that one can hardly realize so much from a one volume text. Treatment is presented not only from the authors' viewpoint but the authors have drawn extensively from their colleagues. Treatment carries up to the present knowledge of penicillin in the management of syphilis.

This text may well be considered a classic in this field of endeavor.

P. W. S., Jr.

NEWS ITEMS

Captain Henry Herbert, who formerly practiced in Florence, was visiting in South Carolina recently. He is now stationed at Bryan, Texas.

The Coastal Medical Society held its regular monthly meeting in Walterboro with Dr. J. N. Walsh, President, presiding. Dr. V. W. Brabham, Jr., of Orangeburg, read a most interesting paper on ENDOMETRIOSIS. This paper was discussed by Drs. A. E. Baker, George Bunch and Robert Bailey. Dr. Robert Wilson, Jr., of Charleston, gave a very timely and instructive discussion of the DIABETIC MANAGEMENT OF THE SURGICAL PATIENT. The

meeting was followed by a delightful steak dinner.

On May 3rd., Dr. Chapman Milling of Columbia presented to the Medical History Club of Charleston a paper on Dr. George Milligan, a Charleston Colonial physician. The History Club of Charleston has been meeting regularly for twenty years.

Dr. W. Thomas Brockman, President of the S. C. Medical Association, was the speaker at a meeting of the Buncombe County Medical Society in Asheville, N. C., on June 18. His subject was EVERYDAY DISEASES OF RECTUM AND COLON OR IS PROCTOLOGY JUSTIFIABLE.

PUBLIC HEALTH NEWS

DR. KENNETH LYNCH RESIGNS FROM EXECUTIVE COMMITTEE

DR. JOSEPH I. WARING OF CHARLESTON ELECTED

Dr. Kenneth M. Lynch, who served as a member of the Executive Committee of the State Board of Health for ten years and who succeeded Dr. F. M. Routh as Chairman May 1, 1940, resigned May 23, and Dr. Joseph Ioor Waring of Charleston was elected to fill the vacancy.

In offering his resignation to Governor Ransome J. Williams, Dr. Lynch explained that it was necessary because of a "lack of time for the Board's work." The resignation was accepted with deep regret.

Dr. Lynch, a native of Texas, was instructor of pathology at the University of Pennsylvania, 1911-1913; professor of pathology at the Medical College of the State of South Carolina, 1913-1921; private practitioner in Dallas, Texas, 1921-1926, and since 1927, professor of pathology at the Medical College and pathologist to Roper and other hospitals. He became Vice Dean of the Medical College in 1935, and Dean in December, 1943. A doctor of laws degree was conferred upon him in 1930 by the University of South Carolina, and on May 29 of this year a similar degree was conferred upon him by the College of Charleston.

Dr. Lynch's successor to the Executive Committee, Dr. Waring, has been practicing medicine in Charleston since 1927 and is one of South Carolina's leading pediatricians. He was graduated from Yale Medical School in 1921. He served his internships and residencies at Roper Hospital in Charleston, Bellevue Hospital and Willard Parker Contagious Diseases Hospital, both in New York City.

Before commencing the practice of pediatrics in Charleston, Dr. Waring for four years carried on a child health demonstration in Rutherford County, Tennessee, under the auspices of the Commonwealth Fund. He is Associate Professor of Pediatrics at the Medical College of the State of South Carolina; Visiting Pediatrician for Roper Hospital; Clinician for the Charleston County Tuberculosis Association; and Clinician for the Charleston County Health Department.

For one year Dr. Waring was Acting Editor of the Journal of the South Carolina Medical Association, and since that time he has served on the Editorial Board. As a writer, he is nationally known in the medical profession, since many of his articles have been published in leading scientific journals. For a number of years he was Secretary of the Medical Society of South Carolina (Charleston Medical Society). He is President of the Alumni Association

of the Medical College of the State of South Carolina; Chairman of the Committee on Arrangements of the Refresher Course for Physicians, which has been held at the Medical College for the past four years; and for the past year he has served as a member of the Technical Advisory Committee on the Emergency Maternal and Infant Care (EMIC) Program, which is conducted through the Division of Maternal and Child Health of the State Board of Health.

LIFE ABOARD SHIP

BY

R. W. Ball, M.D.

(Dr. R. W. Ball, former Director of the Division of Maternal and Child Health and now a Lt. Col. in the Army Medical Corps, is stationed on Okinawa. The following poem was written by him while en route to that destination.)

After months of preparation, and some "briefing" for the trip

We hoisted gear upon our backs and went aboard the ship.

To our designated quarters just between the weather decks

We repaired in haste and dumped our stuff and wondered what was next.

Those quarters were so "chummy," with the bunks four levels high;

A ceiling low; the aisle between the bunks was just a lie.

A shrug of resignation, then a grin, a laugh, a cheer.

(We might as well make the best of it) and then on deck for air.

Anticipating pleasure from a cigarette derived

We all lit up and took a puff, but pleasure was short-lived.

Loud speakers blared in angry tone, "the smoking lamp is out

Throughout the ship" because when tied at dock 'twas wrong, no doubt.

After hours at the dock we then got underway;

Set out to Sea. For company we had the ocean's spray

And flying fish. The noonday sun shone from a cloudless sky.

The ship would roll, a few were sick and feared they would not die.

We looked around for seats on deck 'pon which to place our rears

But standing-room was all there was, because there

were no chairs.
 We stood up here, we stood up there, and then we stood around.
 And so throughout the afternoon no comfort could be found.
 And evening meal, then out on deck to see the sun go down.
 We wondered then what we had done to cause the Skipper's frown,
 Because, with daylight still, and long before the sun could dip
 Came orders thru the microphone, "Prepare to darken ship."
 "All hands, all troops, all officers at once will lay below"
 We all complied, but wondered then just where in hell to go.
 So back to our compartment, then with hatches not all closed
 We lay below, we lay around—stepped on each other's toes.
 We climbed into our bunks to read—there was nothing else to do.
 There wasn't any place to go (the "head" was crowded too).
 We'd then climb back down to the floor and sit—if there was space.
 And frequently en route you'd step upon your neighbor's face.
 In compactness of compartments we were stuffed there, man to man
 (And a temperature of ninety) just like sardines in a can.
 Then back to bed into our bunks to try to get some sleep,
 The ship would roll and we would toss—like riding in a jeep.
 The fragrance of the atmosphere (no fresh air in the place).
 Half-naked men perspiring—A pig would hide his face.
 So after tossing all the night, at last the morning came.
 We're up at dawn, the sights to see—But ever it's the same:
 The guard approaches, "Sorry Sir, you'll have to lay below.
 The smoking lamp is not yet lit. The ship's still dark," and so
 We retire to the bathroom which, on ship, is called the "head"
 To shave the whiskers off the face—but cut the face instead.
 Someone had opened starboard hatch, causing indoor

lights to "out"
 You yell and then profanely ask just what it's all about.
 Then one gets beneath the shower and gets lathered, head to foot
 Off goes the water suddenly—soap in your eyes to boot.
 In time we get to breakfast in the wardroom 'tween the decks.
 It's crowded—grapefruit in your eye or elbows in your necks.
 Then follows a short breathing spell, in which there's naught to do.
 Till nine, when calisthenics start, with ship a-rolling too.
 We go thru that for a little while, before we're put at ease.
 At ten a lecture down below, and a course in Japanese.
 In leisure hours one can read, or play perhaps some chess,
 Or poker, checkers, or write home—which ever suits one best.
 Right when you're in the midst of it, comes thru the interphone
 "Abandon Ship. This is a drill." Comply again and groan.
 And so time passes. Day by day there's very little change.
 If we didn't gripe some now and then it would indeed be strange.
 But when we reach the target and we all have gone ashore.
 We'll wish to God we were back on ship—We'd never gripe no more.

**TRUTH IS STRANGER THAN FICTION,
 ESPECIALLY WHEN IT COMES TO
 SOME PEOPLE'S NAMES**

How would you like to be introduced to Miss Sadie Ticklebritches? Suppose you received a letter signed: Pleasant Roast? What would you do if you had to write a check to the order of Margaret Mdora Maryella Lettie Tomasina Dorey May Durham? They are all possibilities, for there are real people in South Carolina with those very names. And they're legal too, because they're registered with the Bureau of Vital Statistics.

Here are a few more you might run into, too, before you get much older: Whispertell Johnson, Castoria Jenkins, Invasion Moore, Rosie Rumph, Pete and Repete Southen (twins), Seven Richardson, David Quitoff (13th child), Whity Goforth, Esso and Essolene Black (twins), Juquata Garret, Plum and Peach Trotter (twins).

That's their names all right, and they've got birth certificates to prove it!

Hospitals NowAnd Tomorrow

A. C. Bachmeyer, M.D., *Director of Study*
Commission on Hospital Care, Chicago, Ill.

Lack of incentive for young doctors to begin practicing in rural and semi-rural areas is one of the big problems which both the public and the medical groups are facing today. Large hospitals, medical centers and city practices attract many young physicians because of the well-equipped laboratories, skilled technicians and opportunity for continued study.

In vast stretches of rural America there are no hospitals and the small number of physicians which serve those areas must work without the valuable equipment and assistance which a hospital affords.

The nation's postwar planning on local, state and national levels is working toward construction of hospitals to serve those neglected areas. But before any real planning can be done it is first necessary to know exactly what hospital facilities and services are available at the present time.

So last fall the Commission on Hospital Care was established through the efforts of the American Hospital Association and was given the job of taking the vital inventory of the nation's hospital facilities. The Commission on Hospital Care is located at 22 East Division Street, Chicago 10, Illinois.

It is an impartial, fact-finding body and its members are outstanding men and women of national repute who have a sincere interest in public welfare. They include members of the medical, dental and nursing professions; hospital trustees and administrators; public health; medical education; industry; labor; agriculture; public welfare and the fields of sociology and economics.

The work in financed by grants from the Commonwealth Fund, the W. K. Kellogg Foundation and the National Foundation for Infantile Paralysis.

The objectives of the Commission on Hospital Care are to take a census of the present hospital and public health facilities in the nation; appraise their capacity for service; establish standards for evaluating physical facilities, organization and management of hospitals; determine the over-all national need for additional facilities and service; formulate a national coordinated hospital plan and to suggest methods by which that plan can be realized.

National interest in the survey is widespread. Thirty-five states are in one phase or another of their studies. Surveys are in process or about to start in: Iowa, Massachusetts, Michigan, Minnesota, Missouri, North Dakota, New Hampshire and Wisconsin. Survey legislation has been enacted but surveys are not yet started in: Delaware, Indiana, Maine, North Carolina, New Mexico, Oklahoma, Oregon, Rhode Island, Virginia, Vermont and Washington. Survey legislation is pending in: California, Florida and South Carolina. Survey organizing committees have been established in: Illinois, Kansas, Kentucky, Louisiana, Montana, Nebraska, Ohio, Pennsylvania, Tennessee, Texas, and West Virginia. States which are proposing that the Post-War Planning Commission conduct the survey are: Alabama and New Jersey. States which have made preliminary hospital studies are: Georgia, Maryland and Utah.

The commission is conducting a pilot-study in Michigan. The inventory of Michigan's 700 hospitals, including nursing homes and other institutions for

the care of the sick is now nearly completed. The method used in Michigan will serve as a pattern which other states may use in making their surveys if they so desire.

A detailed study of every hospital in the entire country would take more time and money than the Commission has at its disposal. Therefore, each state is being urged to carry on its own study. In this manner, local interest in the problem will be aroused. Each state will become immediately aware of its needs and a desire to furnish adequate hospital service will be stimulated. It is suggested that the survey be conducted by a single designated state agency in close cooperation with the state planning commission and the health department. Representatives of medical, dental and nursing professions, hospital administrators, labor, industry, agriculture, public health and welfare should be represented on each state study committee.

Although each state carries on its own study, The Commission on Hospital Care will act as a coordinating body and furnish a standard questionnaire for use by all states making the survey. Other work materials, as well as the aid of technical consultants, will be provided by the Commission. The final job of tabulating the information will be done by the Commission staff in the national office.

The hospital and the private physician are a team against sickness and disease. For a long time physicians and hospitals have worked together — and fought together — to preserve life and health. The technological advances of medicine have made that teamwork more vital and more effective than ever before.

Now that the health spotlight has swung to the hospital, we are becoming increasingly aware that there are not enough hospitals to serve everyone who needs hospital care.

But the spotlight has also swung to *planning*. Before we build, we have to *plan* so that every area—rich or poor—will have its share of the vital hospital facilities.

That is why the Commission on Hospital Care is directing this county-by-county survey of the nation's hospitals. In this way we can put a magnifying glass to the hospital problem in each area, yet retain a picture of the overall needs of the county, the state and the nation.

It is part of the Commission's undertaking to solve the problem of uneven distribution of hospitals and physicians. We know that doctors are not attracted to areas where there are no facilities. So we must be certain that the postwar hospitals are built in the right places. Each community can't just "up-and build a hospital" but must fit itself into the plans of its neighbors.

For all of these reasons, a survey to determine need is vital. The Commission on Hospital Care urges all members of the medical profession and all other public-spirited citizens to give their utmost cooperation to this inventory in order that our nation's hospitals may be built where they are needed and where they can be operated to the best advantage of all of the people.



When Weight Gains **ARE NEEDED**

For the underweight patient just recovered from severe acute or chronic illness, increase in weight may be difficult to achieve with the customary high-caloric diet. Yet restoration of normal fat deposits and correction of nutritional deficiencies are essential for rapid return of strength and resistance to infection.

The intake of essential nutrients high in calorific value is expeditiously accomplished by including Ovaltine in the diet. This tasty food drink, made with milk as directed, is

enjoyed by all patients both as a mealtime beverage and between meals. Not only rich in calories, it also provides generously other nutrients urgently required: biologically adequate proteins, highly emulsified fat, B complex and other vitamins, as well as the essential minerals iron, copper, calcium, and phosphorus. The low curd tension of Ovaltine favors quicker gastric emptying, hence the appetite actually tends to become enhanced through this desirable behavior.

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PROTEIN	31.2 Gm.	VITAMIN A	2953 I.U.
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CALCIUM	1.104 Gm.	RIBOFLAVIN	1.278 mg.
PHOSPHORUS903 Gm.	NIACIN	7.0 mg.
IRON	11.94 mg.	COPPER5 mg.

*Based on average reported values for milk.

The Journal of the South Carolina Medical Association

AUGUST, 1945

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BACKGROUND

Three Decades of Clinical Experience

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Mead Johnson & Company, Evansville, Ind., U. S. A.



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Toxemias of Late Pregnancy

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Sixty-one South Carolina mothers died of pregnancy toxemia in 1943-1944. Dr. Hilla Sheriff, acting director of the Division of Maternal and Child Health of the State Board of Health, has so reported in a recently completed study. She divides these deaths into those caused by toxemia of pregnancy and those caused by puerperal toxemias. Some deaths in the first group may have been caused by toxemia of early pregnancy (hyperemesis gravidarum), but such deaths are rare and their inclusion has not changed the figures materially. Puerperal toxemias are for all practical purposes pregnancy toxemias, since in most instances the condition had its beginning in late pregnancy even though death did not occur before delivery. Therefore, we may conclude that all or nearly all of these deaths were caused by toxemia of late pregnancy, and so again for the second successive year, toxemia heads the list of causes of maternal deaths in South Carolina. There was a drop in the number of these deaths, the figure for 1942-1943 being 95. Thus, there were 34 fewer deaths from pregnancy toxemia. There were 55 fewer maternal deaths from all causes. In other words, toxic deaths were reduced approximately one-third while all maternal deaths were reduced approximately one-fifth. This is encouraging, but the figures are too small to be very significant. However, it is significant that the maternal death rate in South Carolina has fallen steadily since 1938 when it was 7.5 per 1000 live births. It was 4.1 last year. We may boast progress but lest we be too complacent, it must be stated that the maternal death rate in the United States registration area in 1942, the latest figure available, was 2.59.

Deaths from toxemia of pregnancy must of necessity be considered largely preventable deaths. If so, then why do women continue to die these deaths? It appears to me that in general there are two causes for them. Ignorance and procrastination on the part of the deceased is an important cause. Note that I did not say poverty, for I believe that no one in South Carolina would be denied adequate prenatal

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care because of poverty. Neither is ignorance wholly responsible, for all doctors see frequently evidence of gross neglect of this and other health matters because of procrastination. However, I am convinced that the cause of all these deaths does not lie wholly with the deceased. The medical profession must assume blame for some of them, and doctors are blameworthy because of inertia and a mistaken idea of what constitutes conservative practice. I am convinced of the correctness of this view by what I see and by what I hear doctors say. It is not infrequent that patients sent into our hospital services or to our clinic have been under medical observation and treatment for days or weeks and yet have not improved, but instead have grown steadily worse and have already been allowed to continue their pregnancies beyond the danger point, while treatment programs have been casual and inadequate. Not long since a medical friend told me that he had a patient whom he planned to send to me soon if she did not fall into labor. He stated that the patient was carrying a blood pressure of over 170, was very edematous, and had become so blind that *she ran into objects as she walked to his office*. That is certainly an instance of carrying conservatism too far. If her condition was one of true preeclampsia, her life and that of her child were being unnecessarily endangered. If it were one of chronic nephritic toxemia, not only were these dangers present, but she was suffering irreparable and permanent damage to her kidneys.

South Carolina doctors know how to treat toxemias of pregnancy, but it will not be amiss to outline my ideas and practice on the subject. The articles in standard textbooks, I find, are unnecessarily technical and comprehensive and hence are confusing to the hurried student. Further, many

authors continue to include even in newer editions practices which have been dropped by most men. There is confusion both in discussion of treatment and in classification upon which diagnosis and treatment is based.

Complicated and long classifications are useful but they are not desirable or useful to the clinical man seeking aid in handling a troublesome case. The simpler the classification the better he understands it, and the more concise the methods of treatment suggested the greater assistance he will receive. To illustrate the lack of assistance to be derived from these highly scientific and somewhat speculative articles, let me cite a true happening. There was a new interne on duty in the emergency room when a gravida near term applied for treatment. When he found her blood pressure to be about 160 he decided that she must have toxemia. He glanced hurriedly through the chapter in Dr. Lee's text and sent the patient to the ward with orders for every phase of treatment suggested in the book, and it was quite a list.

Perhaps the most generally useful classification of toxemias of late pregnancy is:

1. Preeclampsia.
2. Eclampsia.
3. Chronic nephritis made worse by pregnancy.

This classification omits low reserve kidney, which is not a true toxemia, but might be thought of as pre-preeclampsia. It omits yellow atrophy of the liver which is very rare, which is usually identical with delayed chloroform poisoning and which is not a true toxemia of pregnancy. It omits essential hypertension which is not toxemia of pregnancy. It does not break eclampsia up into separate groups.

Although chronic nephritis, even when made worse by pregnancy, is not a true toxemia of pregnancy, it has long been included in all classifications. There is practical advantage in including it because of the fact that it is difficult frequently to differentiate it promptly from more or less severe pre-eclampsia. If the toxic patient is left with no vascular-renal sequelae, the condition was probably pre-eclampsia, and if there is continued elevation of blood pressure, low urinary concentration, et cetera, then the patient was and is a chronic nephritic.

Preeclampsia and eclampsia are stages of the same process, and for all practical purposes the dividing line is the appearance of convulsions.

The best treatment of severe toxemia is prevention and prevention necessitates antenatal care. This care must be medical, and must include observation, instruction and active treatment of deviations from normal. So often care is simply observational. So often it contains no instruction as to hygiene of preg-

nancy, danger signals and safeguards. Prenatal visits should be at not greater than bi-weekly intervals after the sixth month, and should be weekly or oftener during the last month. The danger signals, persistent headaches of increasing severity, edema, particularly if it affects the face, and diminished urinary output should be discussed and the patient should be asked to report these promptly rather than waiting for the next scheduled visit.

At every visit, a urine analysis should be done, blood pressure should be taken and recorded, and the patient should be weighed. Voided urine frequently will show a trace or more of albumin. If there is doubt, the patient should be catheterized. However, if the blood pressure, both systolic and diastolic, is normal for that patient (and there must be a record of previous readings to know what is normal for her) then one is reasonably safe in assuming that even a fairly heavy trace of albumin in voided urine is not significant. An increase in weight of more than one pound per week is a danger sign, although it does not necessarily signify impending toxemia. Total weight gain in pregnancy should not exceed twenty-five pounds. Twenty pounds is preferable unless the patient begins pregnancy severely under nourished. If the patient begins pregnancy already overweight, an effort should be made to hold the weight down to the initial weight. Excessive weight gain courts toxemia because of extra and unnecessary burdens placed on liver, kidney and circulatory systems. A sudden gain of several pounds usually means occult or visible edema.

Edema is not necessarily a sign of toxemia. Most pregnant women have more or less pitting edema of the feet and legs, especially in hot weather, caused by uterine pressure in the pelvis, lessened muscular activity of the legs, and the almost, or quite, physiological changes in water balance and in capillary permeability in pregnancy. Generalized edema, without blood pressure rise and significant urinary changes, should suggest an underlying condition other than toxemia. One such patient was promptly relieved by withdrawing baking soda which she had been taking for "acid indigestion." Others will be found to be eating excessively of salt. It should be remembered that it is the sodium radical which is responsible for water retention in these cases.

A not infrequent cause of general edema, not due to toxemia and without accompanying blood pressure rise and urinary changes, is nutritional, due to deficient proteins in the diet. This condition may be so severe that intravenous blood or blood plasma may be desirable, but for patients who are under observation an increased ingestion of animal protein, lean meat, milk and egg white, will rapidly clear up the situation. In hospital practice, one frequently sees this condition brought on or made worse by that antedated instruction to pregnant women, hypertensive patients and chronic nephritics, namely, "Don't eat any meat," or "Don't eat any red meat," or "Don't eat any hog meat"—and some of these indi-

viduals can't or won't drink milk. My patients are instructed to eat an average serving of lean meat (fish, flesh or fowl) and to drink a quart of milk each day. Babies, even girl babies, are not made out of sugar and spice, but instead they require proteins and minerals and vitamins, and so do their mothers.

There is no certain level or series of levels of blood pressure that differentiates early preeclampsia, late preeclampsia and eclampsia, nor is there a definitive standard of albuminuria. When the blood pressure begins to rise from an individual basic level, one should be on guard. When this is accompanied by albuminuria, the patient is a candidate for active treatment and for more frequent observation. Active treatment does not mean a lot of medicine. Rest is the first essential, and elimination of salt from the diet, and limitation of diet qualitatively so far as rich and difficultly digested foods are concerned and quantitatively in all respects except liquids, complete the program. Regular bowel elimination should be maintained. There is no special virtue in magnesium sulphate to accomplish this.

If this line of treatment does not bring the blood pressure down or at least stop its rise, the patient should be put to bed and the diet restricted to milk, fruit juices and sugar. For the wholly conscious and cooperative patient, without excessive edema, intravenous glucose is not necessary. If one ounce of Karo syrup is added to each glass of milk or fruit juice, the blood sugar will rise, diuresis will be encouraged, and the liver will have the protective influence of glycogen.

It is preferable that patients who do not improve under this regime be promptly hospitalized. When the blood pressure of a patient, previously running 120 or less, reaches 150, the outlook for continuing the pregnancy is not good. Many preeclamptics become eclamptics by reason of their first convulsion with a pressure no more than 160. But hospital treatment signifies only more rest and closer and more constant observation. There is little change in treatment except that glucose intravenously probably should be given several times a day if the urinary output is not highly adequate or if the edema has persisted. I prefer 25 per cent glucose prepared by adding two 50 cc. ampules of 50 per cent glucose to 100 cc. sterile water, and giving the 200 cc. so obtained three or four times a day. This has the advantage of being adequately hypertonic and is not so quickly damaging to the veins as is 50 per cent glucose solution.

One should not delay too long in terminating pregnancy. If in spite of treatment, there is not adequate response by a fall in blood pressure, a lessening of albuminuria, with an increase in kidney excretion, and a marked reduction in edema, termination of pregnancy should be brought about in the interest of both mother and child—and this should be done before the onset of convulsions. Except in rare instances this does not mean caesarean section. It does mean induction of labor and, unless the pa-

tient is very near or quite at term with an engaged presenting part, attempts at pure medical induction are usually a waste of time. If the cervix is prepared for labor, that is if it is foreshortened and soft and dilated a finger breadth or more, I prefer induction by perforation of the membranes and drawing away all or most of the amniotic fluid. It is the latter and not the former which is responsible for the onset of labor. If the cervix is not prepared for labor, it can usually be prepared by a preliminary firm guaze vaginal packing for 24 hours.

After perforation of the membranes, onset of labor can be hastened by m. ii doses pituitary extract *intramuscularly* at 30 minutes intervals until labor is established. A dose or two before perforation will prime the uterus, as it were, will tend to push the presenting part into the inlet and will so inhibit prolapse of the cord.

If the cervix is long and conical and firm, if there is question about cephalo-pelvic proportions, if there is some unusual importance with regard to birth of a living child, then caesarean section may and perhaps should be done, if done under other than general inhalation or intravenous anesthesia.

After convulsions have occurred, the problem is somewhat different and the outlook is worsened. The first task is to stop the convulsions. A quarter of a grain of morphine should be given as a preliminary. I like to follow this with six grains of sodium amytal per rectum. This is preferred to I. V. or I. M. barbiturates, although it does not act so quickly, because it is much safer left in the hands of a nurse or interne or even a relative for repetition. Intravenous glucose, 25 per cent, is given 200 cc. every four hours. The patient is kept warm and quiet. I rarely use I. V. magnesium sulphate nowadays. It was formerly given as an anticonvulsant and as a dehydrating agent, particularly of the brain. The barbiturates are more efficient anticonvulsants and hypertonic glucose is equally as efficient and is a much safer agent to draw water from the tissues and to stimulate diuresis.

Chloroform is no longer given during the convulsions. The patient never did inhale any of it anyway until the convulsion was over. It is preferable to use oxygen to relieve as rapidly as possible the anoxemia produced by the cessation of respiration and the intense muscular work during the convulsions.

These patients usually sooner or later go into labor spontaneously and the baby has usually already perished. Accouchement force is never indicated, caesarean section is rarely if ever indicated before convulsions are controlled, and induction of labor should be postponed until improvement has begun.

When death occurs the immediate cause is myocardial failure beginning with the right heart and edema of the lungs. Because of this it is wise to digitalize toxemic patients as a precautionary measure.

The significance of blood pressure levels in chronic nephritis with hypertension is vastly different from

that in preeclampsia. Many of these women have a pressure of 160 or more before pregnancy. Pressures begin to rise in the first half of pregnancy. Convulsions are not likely to occur before the pressure has risen above 200. Convulsions are not eclamptic but are uremic with the same significance and prognosis as uremic convulsions and coma have in the non-pregnant.

However, the treatment is essentially the same as for preeclampsia, with this exception. Since excessive hypertension is likely to occur before viability of the child, and since the concern with regard to the mother is not only immediate but is also remote, the question of therapeutic abortion enters into the picture frequently. Each case should be decided on its own merits and in a rational manner. If the woman

already has a number of small children, the life of the unborn child, already greatly threatened by the disease of the mother, should be sacrificed in the interest of the children's welfare. If there have not been other children, an effort to carry the patient to viability of the child is usually wise. To push one's luck too far and try to carry her to term is usually hazardous to mother and child.

Treatment of intrapartum and postpartum eclampsia is similar to that of antepartum disease, except that the matter of evacuation of the uterus causes no concern and offers no aid in treatment. And in cases of either preeclampsia or intrapartum eclampsia evacuation of the uterus does not substitute for careful general medical treatment postpartum. Treatment instituted before delivery should be continued and is withdrawn gradually as improvement occurs.

Bacillary Dysentery (Shigellosis)

J. I. WARING, CHARLESTON, S. C.*

Although this subject may be rather worn, I feel that there are several good reasons for presenting it to you. First, no self respecting pediatrician can let many years elapse without talking about diarrhea or dysentery, thereby flying his banner with the sign of the folded diaper and the loose stool rampant. Second, figures show that in South Carolina for the whole year 1942 only 97 cases of bacillary dysentery were reported, the number which any one busy practitioner might well see in one summer; these figures indicate either that the disease was not recognized or that there was widespread diffidence in reporting it. Third, hearing a colleague state only a few days ago that he was unaware that the sulfonamides were effective agents in treatment of dysentery, I felt that mention of their use and value might not be amiss.

Somewhat over a hundred and fifty years ago Benjamin Rush, writing under the title "An Inquiry into the Cause and Cure of the Cholera Infantum" wrote as follows:

"By this name I mean to designate a disease, called in Philadelphia, 'the vomiting and purging of children.' From the regularity of its appearance in the summer months, it is likewise known by the name of 'the disease of the season.' It prevails in most of the large towns of the United States. It is distinguished in Charleston, in South Carolina, by the name of 'the April and May disease,' from making its first appearance in these two months."

Charleston and all of South Carolina still have the "cholera infantum" a broad term now broken down into a number of better recognized entities, of which bacillary dysentery is a most common and important member.

*Read before the First District Medical Society, Walterboro, June 21, 1945.

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Bacillary dysentery, or better, shigellosis, is caused by a group of organisms, the shigellae, which vary considerably in respect to the severity of symptoms produced. Not all of them cause the typical dysenteric picture with abdominal cramps, tenesmus, frequent loose stools containing blood, pus and mucus. Some symptoms due to this group may be regarded as only simple diarrheas unless cultures are made, and in fact, it is likely that the majority of infections with shigellae are mild. On the other hand, some other organisms may produce the dysenteric syndrome. Of the shigella group, the Flexner type is the most common, and responds best to treatment, the Sonne type is next commonest and is less virulent, but also less responsive to therapy. The Shiga type is the worst of all, but fortunately not common in our neighborhood. They all may produce marked pathologic changes in the colon, with intense inflammation and ulceration, in contrast to the noninfectious diarrheal conditions which may be severe even to fatality without causing a recognizable pathological intestinal picture. The toxemia produced by the shigellae may be extreme and rapid.

Looking back in the records of Roper Hospital one finds very few cases of dysentery reported until 1942, at which time there came on the scene a bacteriologist who was interested in identifying the organisms in the stools of diarrheal cases. The result of his work was an indication that true dysentery was a common disease in the children admitted to the hos-

pital. In the children with infectious diarrhea, Flexner types were most common, and a few Sonne and Shiga types were found, as well as various salmonellae and others not in the dysenteric family. No doubt the same prevalence of these several types of organisms would be found over the state generally.

Indeed, so popular has the diagnosis of bacillary dysentery become that 567 cases of this disease were reported for the year ending July 1, 1944. While many of the cases were probably not true shigella infections, nevertheless the figures indicate an awareness of the disease in Charleston County at least, for, strangely enough, not a single case of bacillary dysentery was reported in any other county in South Carolina — except, to be sure, 47 deaths from dysentery were reported from various parts of the state, where it would appear from statistics as they stand that dysentery is a uniformly fatal disease.

Most parents are inclined to attribute the acquisition of a child's dysentery to some vague change of water or milk. Actually these materials are unusual sources of infection, as most instances are due to food contamination by carriers or by flies, or as someone has said, "the repulsive regurgitations, dangerous droppings, and filthy feet of faecal flies fouling food" (Balfour). Fortunately the carrier state is of short duration, lasting ordinarily only a few days, and probably the transmission of the disease is accomplished more often by passage from person to person by hand contamination than it is effected by flies. Hence the important items in prevention are the proper treatment and isolation of active cases, screening, and careful disposal of stools and diapers.

The recognition of infection with the dysentery organism is not always easy. Severe diarrhea may be due to other infections. In passing it might be said that our serious diarrheas in the summer are seldom parenteral or other than infectious in a child reasonably well fed. For practical purposes, sudden diarrhea with abdominal cramps and much mucus, pus, or blood in the stools is bacillary dysentery until proved otherwise and deserves anti-dysentery treatment. As a matter of experience, suspicion of dysentery should also be laid on the child who is suddenly seized with fever and convulsions without other physical signs, for there have been cases of shigella infection in which death has occurred even before the diarrhea developed. In an early stage of the ordinary case before typical stools appear, some intimation of the infectious nature of the disease may be given by the presence of pus cells in the stool examined microscopically. Stool cultures require too much time to be of practical value in the early stage of treatment, but help in guiding later handling.

Usually the diagnosis of shigellosis is fairly evident. Diarrheal states due to salmonella and to Morgan's bacillus may be confusing. One distinguishing feature is their lack of response to treatment. Staphylococcal diarrhea is usually quite explosive. Poisoning with various things and the rather rare intussus-

ception must be borne in mind.

Recent years have changed the prognostic picture in these infections. The sulfonamides have done as much for them as they have for pneumonia, and it is seldom that one has to witness now the prolonged and tragic sufferings of the dysenteric patient, any more than one must wait anxiously for the dilatory crisis of an untreated pneumococcal pneumonia.

Not only the sulfonamides but also the newer uses of blood, plasma and similar substances have gone far toward removing the dangerous character of dysentery. The availability of all these substances makes treatment more promising, and home care may be feasible. For the severe case the hospital is the proper place.

Let us follow the treatment of a sample case with severe dysenteric symptoms. First the child is put to bed, snatched from the overanxious arms of the mother who attaches some therapeutic value to rocking or bouncing or taking the patient over to the neighbors house for fresh air. Next an effort is made to thwart the solicitous grandmother with her impending dose of castor oil, a substance well fit for aggravating intestinal inflammation, and purging of any sort is avoided. Then after discouraging the suggested use of such things as chalk mixture, bismuth, paregoric and a collection of various proffered nostrums, one can proceed with proper dosing with the effective sulfonamides and proper maintenance of body fluids given parenterally when the oral approach is not adequate. Sometimes in the enthusiasm for the needle the normal oral channel is forgotten.

Which drug to use is still somewhat questioned. For a time the less absorbable sulfaguanidine and sulfasuxidine were considered more effective and less dangerous, even when given in large doses, but much imposing current opinion has swung toward the readily absorbed compounds such as sulfadiazine and sulfapyrazine, which are said to reach the areas of active infection best by way of the blood, as well as approaching them in the bowel. Some of us still have an unsupported clinical affection for sulfathiazol. Perhaps we will use it in this case, in the usual dose of a grain per pound per day, doubling our first dose or two, or we might use sulfadiazine similarly, or perhaps sulfasuxidine in dosage from three to five times as heavy. If vomiting is a hindrance, we can give the soluble drugs intravenously or subcutaneously. If we give a prescription, it should include enough for at least 3 or 4 days, as we have all seen the relapses which follow the too brief use of the drug, and we must remind our patients that a dose "every four hours" means night as well as day. Most of us prefer giving the drugs as powders which may be mixed with a spoonful of food or drink or given in some relatively mild suspension such as chalk mixture.

If this patient is dehydrated, he must be replenished with considerable quantities of water by mouth, or isotonic solutions of saline, glucose, or molar-lactate (Hartmann's) intravenously or under the skin. Per-

sons other than parents seem to be able to persuade a child to take much fluid by mouth. After hydration is accomplished, plasma, blood or Amigen, a solution of aminoacid, may be given by vein. The last may also be given under the skin (Amigen 10%, glucose 10% in lactate-Ringer's solution).

Our child requires no elaborate diet. In the first 12 hours of his illness water alone is given, then he is given liquids, preferably those similar to those of his accustomed choice. Boiled skimmed milk or buttermilk or a diluted formula may be followed gradually by strained foods as symptoms improve. Pectin-agar, apple powder and similar preparations seem to have no specific value in dysentery. A reasonable supply of essential vitamins in concentrated form, and if necessary, given parenterally, should be assured, especially when the child is being given large quantities of fluids.

This restless child may be made quiet by phenobarbital or paregoric if necessary. His excoriated buttocks may be exposed to the heat of an electric bulb or baked in the sun, and some relief of his tenesmus

may be afforded by a 5% cocaine or a 4% tannic acid ointment in the rectum. An enema for distension at the onset may give some relief, but later attempts may aggravate the inflammatory state of the bowel.

Most parents ask for treatment to "check" the diarrhea, and unless informed, may be disappointed in the time required for the action of the drug. Twenty-four hours seems to be an approximate minimum, but mother wants a quick medical stopper.

Now when there is a much too indiscriminate use of the sulfonamides in all sorts of infections which may or may not be benefitted, one hesitates to stress the use of these drugs in shigellosis for fear that every loose stool will inaugurate a course of doubtfully effective medication. The child who has sudden diarrhea, cramps, fever, mucus, pus or blood in the stool should be treated with sulfonamide until we are convinced that he does not have shigellosis. Milder symptoms make judgment more difficult. Clinical suspicion must be the guide at the beginning, but let us hope that our medical natures will not be too super-suspicious.

Recent Progress in Medicine Science

R. M. POLLITZER, M.D., GREENVILLE, S. C.

In order to obtain a proper perspective, let us spend a few minutes in the dim and distant past. "Medicine is as old as the human race; as old as the necessity for the removal of disease."—Haeser. Sekhet, in Egypt 3000 B. C., used the lancet and cupping instruments. The Ebers Papyrus, written in 1500 B. C., in Egypt, discusses pills, potions, incunations, inhalations and plasters. In India, about 700 B. C., in the Fourth Vedas (Books of Wisdom), there is information about surgery and medicine; also sanitation, hospitals and institutes for the blind and the lame are discussed.

Origin of True Medicine

True medicine, however, originated in the time of the Greeks in the third and fourth century B. C.; that is, attention for the first time was paid to the symptoms and the course of disease. The sick went to the temple of Asklepios (Aesculapius). At first only prayer and sacrifices were employed. But since people flocked there from all over, there was a great opportunity to observe illness. The importance of baths and diet were recognized. The priests selected only the most promising cases for treatment. Hence there were many cures and the temple was well advertised.

Hippocrates, born 460 B. C., was the son and grandson of physicians; one of the keenest observers and a philosopher; he wrote very clearly and stressed the study of sickness. He divorced the phenomena of disease from superstition and supernatural forces. Hippocrates upset old mysticism dating back to 3000

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B. C. His writings spread all over the world. Soon, in Alexandria, the center of the learned world, dissections were being made.

Galen, who was born 130 A. D., was well grounded in anatomy and physiology. His observations were good but his interpretations were poor. His writings completely dominated medicine for thirteen centuries.

Modern Medicine

And so to Modern Medicine: Pasteur, Koch and Ehrlich are the founders of Modern Medicine. More progress has been made in medicine since 1850 than in all the preceding centuries combined.

In 1880 Louis Pasteur discovered the Staphylococcus and Streptococcus. These bacteria are extremely common and produce much disease of serious nature. He began his career as a chemist and then spent some time in physics and became a bacteriologist without any desire on his part. His first studies were on fermentation, its cause and prevention. He helped the French nation by overcoming their difficulties in

the making of beer and wine. Next he studied the diseases of the silkworm. Sheep at this time were dying in large numbers from Anthrax. He discovered the Anthrax Bacillus. His work in this and in other lines, while scientific, was extremely dramatic. In the words of a great medical historian, A Castiglioni, "One can say, without exaggeration, that the civilized world correctly recognized in Pasteur, one of the greatest and noblest pioneers of civilization."

Also in 1880, Eberth discovered the typhoid bacillus. As a rule before one is able to make much progress in the study of a disease, the cause has to be found. This step was of tremendous importance as Typhoid Fever occurs in many parts of the globe and is often fatal.

The following year Laveran discovered the malarial parasite. He did his research in North Africa. Science is greatly indebted to him. Malaria even today, is the commonest of all diseases. It is worldwide. Malaria has lost more battles than swords or bullets. According to some historians, it was an important factor in the decline of the Roman Empire.

T. B. Claims Great Victims

In 1882 Robert Koch discovered the tubercle bacillus. Tuberculosis for ages was the commonest cause of death. "The germ of Tuberculosis has played a prominent role in the drama of civilization. It has claimed for its victims the greatest of mankind. It stilled the divine music of Chopin; it stayed the pen of Keats; it numbed the brain of the philosophical Spinoza; it cut down Schiller, Stevenson and Chekov in their very prime. It left its mark on Raphael, Mozart, John Paul Jones and Lord Nelson." It shortened the lives of some of the greatest doctors: William Withering, Paul Ehrlich, Rush, Bichat, Laennec, Trudeau and numerous others. Today, because of scientific knowledge, Tuberculosis has dropped to seventh place in the list of the most deadly enemies of mankind. Koch was truly a great man. He was a typical German; extremely scientific and precise; differing completely from Pasteur, who had a genial disposition and loved humanity.

In the following year Edward Klebs discovered the diphtheria bacillus. Diphtheria for centuries has killed many children and even exterminated families. Because of its contagiousness, it was feared and treated more vigorously than wisely. Today our knowledge of Diphtheria is practically complete.

In 1884 Crede introduced silver nitrate to prevent Infantile Conjunctivitis. Thousands of babies prior to this became blind at birth because of gonorrhea of the eyes. This they contracted from their mothers. Today laws require that silver nitrate be put in the eyes of newborns. The disease is now almost unknown.

The following year Pasteur discovered the rabies preventive. Inasmuch as rabies or hydrophobia has a mortality of 100%, anyone bitten by a mad animal must take the preventive to escape death. No one can estimate the number of lives saved since this discovery. If Pasteur had done nothing else, this alone

would have been sufficient to make his name immortal.

In 1886 pasteurization of milk for infants was introduced. This, while only a corollary of the recent knowledge of germs, has saved millions of lives.

In the next year Weicheibaum discovered the meningococcus. Since his time and partly through his discovery the mortality has dropped from 90% to 5%. Meningitis often occurs in epidemic form and previously struck terror to whole towns and countries.

In 1889 Behring discovered diphtheria antitoxin. (Mortality then about 60%, now 5%). By this discovery the disease is treated with ease and if recognized early, is one of the most curable of all diseases.

The following year scientific endocrinology had its beginning. Man has two kinds of glands, those with, and without ducts. The ductless pours its secretion into the blood. This circulating has marked effect on different organs and tissues, transforming the individual as regards his pulse, blood pressure, metabolism, emotions and mentality. (Thyroid, Pituitary, Adrenals, Pancreas, Pineal, Gonads.) To a large extent the endocrine glands are the basis of personality.

In 1891 Quincke introduced lumbar puncture. This has enabled us to examine the spinal fluid which bathes the brain and spinal cord. Thus one is able to search for bacteria and do various tests so that a diagnosis of a disease of the nervous system can be made.

Three years later, in 1894, Kitasato and Yersin discovered the Plague Bacillus. For centuries the Plague had almost wiped out civilization. In 1348 it swept over Europe, killing one-quarter of all inhabitants. In Athens in the time of Pericles it killed thousands. Today it is under considerable control, and there are vaccines in use.

The next year Eijkman first gave a report on Beri Beri. Beri Beri is very extensive throughout the Orient, affecting thousands and often causing death. It is less common in the United States, but it does occur here. Formerly Beri Beri was thought to be an epidemic disease; now proven to be caused by a Vitamin B deficiency.

In 1898 Loeffler and Frosh investigated filterable viruses. "The viruses cause widespread death, deformity, and loss by disease in man, animals, plants, and insects." They are so small that they pass all filters and are beyond the limits of microscopic vision. Viruses reproduce—hence alive, but crystallize. Some produce disease in man, but many do not. Just as important as bacteria but not as well known so far. To date few drugs have been found that are curative. Well known diseases due to viruses occurring in man: rabies, infantile paralysis and yellow fever.

The same year radium was discovered by Pierre and Marie Curie. This agent is similar in a way to the x-ray; used particularly in the treatment of cancer.

In 1899 Reed and Carroll proved transmission of yellow fever by mosquitoes. Since that time it has been possible by screening and mosquito control to eliminate yellow fever in certain areas. Examples of

this: Canal Zone and Cuba.

Progress Is Rapid

Two years later, in 1901, Takamine isolated adrenalin. This chemical is elaborated by the Adrenal Gland. It is very powerful and is used extensively in medicine today, particularly in heart disease and asthma.

In 1903 Metchnikoff inoculated apes with syphilis; thus the disease could be studied in the living animal.

In 1905 A Einhorn discovered novocaine. This is used as a local anesthetic and has saved humanity much suffering.

The same year Fritz Shaudinn discovered the cause of syphilis (*spirochaeta pallida*). This discovery was of tremendous importance for syphilis is one of the most widespread of all diseases. Also it is a very ancient disease—for some think it was first recognized in Asia about 700 B. C. and mentioned by Herodotus in 450 B. C. However, the first great European epidemic occurred in Italy in 1494.

Bordet and Gengou, in 1905, discovered the cause of pertussis. Whooping cough is very widespread and causes many deaths. In the next year F. G. Hopkins proposed the vitamin theory. This theory is accepted today and our knowledge is now very extensive.

The same year Wassermann introduced the serodiagnosis of syphilis. This laboratory test is used throughout the world and is of the greatest importance in medicine. The next year von Pirquet introduced a skin test for tuberculosis. This has helped greatly in the study and diagnosis of tuberculosis.

In 1908 Ehrlich introduced 606 for syphilis, after a long period of experiment. One dose does not cure, but several doses are of great value. Paul Ehrlich was also the founder of hematology.

Major Russell, in 1909, vaccinated the entire U. S. Army against typhoid fever successfully. In the Spanish American War typhoid killed more than bullets, but in the First and Second World Wars our troops were practically immune. In 1910 Abraham Flexner produced poliomyelitis experimentally in monkeys. This inaugurated the scientific study of an extensive and serious epidemic disease. C. Funk, from 1911 through 1914, investigated vitamins and gave them their names. Although not the cure for everything, many people are marvelously helped by one or more of them.

In 1912 Von Behring employed toxin antitoxin for diphtheria prevention. It is possible by this to protect children early from contracting diphtheria and thus not wait and have to cure this disease. Von Jauregg, in 1917, treated paresis with malaria. Many paralytics and insane have been greatly helped. A year later Dandy introduced ventriculography (xray and air in the cavities of the brain). Thus brain tumors can be located and their removal often made possible. In 1919 rickets was cured by ultra-violet light by Hulschinsky. Many children have this disease. Direct sunlight is of great value, along with proper diet.

Two years later, Banting and Best at Montreal

isolated insulin from the pancreas and treated diabetes. There are a half million people in the United States who have diabetes. Formerly treatment was more difficult and death more frequent. This treatment has made life more tolerable and added many years to the life of the diabetic.

George and Gladys Dick in 1923 discovered the cause of scarlet fever and devised a skin test. Today this is used in many places and is of value. Three years later Minot and Murphy introduced liver as a cure for pernicious anemia. Formerly many deaths were due to this disease.

Professor Gerhard Domagk in Germany, in 1932, discovered Prontosil, the first of the Sulfonamide drugs. It was first used on laboratory animals, then in 1935 on his daughter who recovered from a strep. blood stream infection. Up to 1936 the death rate from strep. septicemia was over 90%, today it is only 10%. This work was published and pursued in England, France and U. S. A. Later it was shown that the drug's efficacy was due to the molecule called Sulfanilamide. This to date has been studied and modified, so that there are over a thousand related compounds now known. Today these compounds are used in the treatment of many bacterial diseases ranging from gonorrhea to pneumonia and meningitis. The best known to date are: Sulfanilamide, Sulfapyradine, Sulfathiazole, Sulfaguanadine, Sulfadiazine, Sulfasuxadine, and Sulfamerazine. By using these drugs we have a weapon against certain germs and are not merely giving symptomatic treatment. Sulfanilamide powder is now used in wounds as a preventive.

In 1929 Professor Fleming of London discovered Penicillin purely by accident, but having keen powers of observation and of deduction, he did some thinking and then investigated. Finally he concluded that this rather common mold had the power of destroying certain bacteria. However, nothing came of his discovery until in August, 1940, when Professors Florey and Chain at Oxford University, by epoch making studies, proved Penicillin's efficacy in a large number of germ diseases. Soon after the attack on us by the Japs in December, 1941, at Pearl Harbor, the United States went into mass production of this agent. Today it is being used very extensively in civil and military life with amazing results. Not only is the drug the most powerful of any to date, but apparently it has no harmful effect. It is usually given by the hypodermic needle either in the vein or in the muscle. Gonorrhea can be cured by it in one day. Judging from many reports it would seem as though even syphilis in most instances can be cured within a few days.

An outstanding addition to medical science in our time is Chemotherapy. Instead of merely treating the symptoms of a disease, certain drugs are studied as to their effect on certain germs, and after being used successfully in animals, are given to people.

The Science of Allergy or sensitivity to foods, pollens, etc., is advancing. Ten per cent of people are

allergic to some agent. Many allergies can be relieved and some cured.

Great Strides In Forty Years

Tremendous strides have been made in the prevention of disease during the past 40 years. This is not dramatic, but most important. Certain diseases have been eliminated in some areas.

Brain Surgery — Formerly conditions within the skull were unapproachable and hopeless. Today many are curable and the mortality has been greatly reduced.

Lung Surgery—A lobe of one lung or even the whole lung can now be removed successfully. This is particularly applicable in cases of cancer. Orthopedic Surgery—Crippled children and the wounded are repaired wonderfully. Orthopedic Surgery and Plastic Surgery is being applied extensively in World War II.

And now we discuss a subject in a different realm. Sigmund Freud of Vienna, is the founder of psychoanalysis, a branch of psychology, which itself is the child of philosophy and physiology. By some writers his work on hysteria published in 1895 is considered as epoch making as Darwin's *Origin of Species* in 1859. In 1890 Freud published his monumental work "The Meaning of Dreams." Those of us who have seen the movie or play, "Lady in the Dark," have some understanding of his contribution. Freud, in addition to many contributions to science and to art, explored the hitherto unknown regions of the mind. Plato wrote "This is the great error of our day in the treatment of the human body, that physicians sepa-

rate the soul from the body." Some think Freud an extremist, while his disciples follow him very closely. Nearly all doctors and psychologists admit that much of his work is of enduring value.

Conclusion

Probably you have noted that the names mentioned are Polish, Russian, French, American, Austrian, Dutch, German, Japanese, etc. All nations have contributed in the onward march of medicine. For as Pasteur has said, "Science has no country." Nineteen centuries ago Cicero wrote, "Men never come closer to the gods than in giving health to men." Men of different lands and of different creeds have added to our health and happiness.

This rambling sketch covering many men and events should show the marvelous progress in scientific medicine within the past 60 years.

These men endowed with brilliant minds and helping hand,
In this brief time have made for us a better land.

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The Editor:

I would like to ask your cooperation in the following matter. We are anxious to have as complete a list as possible of all alumni of the Medical College who have had any part in World War II. This list is to contain the man's full name, rank to date and any citations, awards, etc. Then we particularly want to have a complete list of those who have died in service. Please pass this request on to all, and everyone, who can help with this and ask that the information be handed in AS SOON AS POSSIBLE. Those giving this information please sign name and address and send to Miss Annabelle W. Furman, Librarian, Medical College of the State of South Carolina, 16 Lucas St., Charleston 16, S. C.

Bacteriological and Other Studies in the Public Aspects of Gonococcal Infection

HARRY BOATWRIGHT, M.D.

PART 2 DISCUSSION

Considering the data compiled here and the results of much unrecorded work, it would seem that the very complex medium devised by Peizer and Steffen (1942) is no more effective in inhibiting contaminating bacteria than ordinary chocolate agar to which is added the same amount of nile blue A and soluble starch. The Peizer medium, since it requires many ingredients, is time consuming to prepare. Further, the medium employs fresh horse blood or substitutes human plasma, and it is difficult to obtain these ingredients regularly and in quantity. Horses used in the preparation of streptococci and pneumococci are deemed unsuitable. In our limited series a comparison of the data in tables I and II indicates that on the whole the simpler medium was more effective in inhibiting saprophytic organisms from the female G-U tract than the complex medium devised by Peizer et al.

An examination of the data in table I shows that the medium containing nile blue A showed gonococci present in a few inocula where as the corresponding inocula on chocolate agar had no gonococci; conversely, in a few cases inocula on chocolate agar showed gonococci without any appearing on the corresponding Peizer's medium. This discrepancy is probably more indicative of the fastidiousness of the organism and the element of chance wherein equally viable cells are not equally distributed in the inocula than to differences in the selective action of the two kinds of media.

The use of nile blue in any of the mediums showed no remarkable aid in the detection of the gonococcus organism, even though some inhibition of contamination was evidenced. The use of this inhibitor did not evidence the remarkable advantage expected by the authors in the light of results obtained by other workers. It is admitted that the significance of this work is greatly circumscribed by the limited amount of material examined; but a tendency, at least, is indicated in the use of the various media employed. Also it must be recognized that the subjects examined showed great variation in the extent of the infection, some giving no evidence of any kind of gonorrheal infection, other chronic, atypical or chemically-treated cases giving only suspicious evidence of the presence of gonococci, and others showing marked clinical symptoms supporting the laboratory diagnosis. Consequently the significance of comparing the various media solely for better detection of the gonococcus is further minimized by the limited number of frank cases of infection actually studied.

Since pure culture transfers of the gonococcus in equal amounts of inocula to Peizer's medium, nile

blue chocolate agar, and ordinary chocolate agar showed no significant difference in degree of growth, nile blue in the concentration employed evidently does not effect the organism adversely. At the same time since significant inhibition of saprophytic contaminants was noted in several of the inocula from the subjects when cultured on media containing nile blue, the tendency indicated in this work relative to the advantage of the use of nile blue probably would be greatly augmented if more frank cases of infection could have been contacted and studied.

Examination of the data also shows some discrepancy in the results obtained with different methods of diagnosis employed. Thus the Gram stained smear may be positive whereas the culture was negative. Or the smear may have showed no gonococci while a positive culture was obtained. Frequently the chronic case, the atypical case, or the chemically-treated case of gonorrhea will give negative microscopic results, whereas careful culture will reveal the presence of the organism. These findings emphasize the importance of culture work. Both the stained smear and the culture must be employed in diagnosis.

The data in Table III represent the use of various inhibitory media in the isolation of the gonococcus. The various dyes in the concentration employed (see methods) markedly inhibited contaminating bacteria, but the gonococcus also was inhibited or its growth greatly distorted. The gonococcus colonies appearing on the heavily concentrated nile blue agar and gentian violet agar were small, rough and atypical. They were very slow in developing. Gram stains from these colonies showed a variety of pleomorphic, distorted cells that one would not recognize as being gonococci; however, the chocolate agar controls showed typical colonies and cells. Transfer of the colonies appearing on the dye media to chocolate agar showed no growth, indicating that the cells in the colonies had become non-variable after a brief period of abortive growth. Thus the use of any of these media containing inhibitory dyes, at least in the concentrations employed, is not indicated.

The bacterial flora of the normal and the infected female G.-U. tract invites considerable interest. It is obvious that one should be familiar with the vaginal and urethral flora in order not to confuse normal saprophytes with the gonococcus. It should be stated that the usual flora of the normal female G.-U. tract differs little from that in gonorrheal infection, excepting possibly the presence of more staphylococci as secondary invaders in gonorrheal infection. The invading staphylococcus is often *staphylococcus aureus*, whereas in the normal flora *staphylococcus albus* invariably is present. Diphtheroids of one variety or another are almost always present in the female G.-U.

tract. Many stains of this group of bacteria are encountered, all possessing prominent metachromatic granules. These stains include chiefly long slender Gram negative rods; very small gram negative rods; large, long Gram-positive rods; and short, plump Gram-positive rods.

Another species of bacteria found frequently in the vagina is an unreported organism described briefly as a non-lactose fermenting Gram-negative coccoid rod. This organism was studied in great detail in pure culture, the results of which are compiled in table IV. Familiarity with this organism is very important, for in a stained smear taken directly from the vagina it is impossible to differentiate between this organism and the gonococcus and diagnosis cannot be made with certainty unless gonococci are found within the pus cells. The Gram-negative coccoid rod referred to does not occur within pus cells. Undoubtedly many false positive tests have been based on finding these gonococcus-like pairs of bean-shaped cocci in smears from the G-U tract of the female. A Gram stain of pure culture

of the organism shows in addition to the young coccoid pairs of cells, very short oval rods occurring in pairs and singly which apparently are the older and mature cells of the species. These cells morphologically resemble the small coccoidal rods characteristic of certain strains of coliform bacteria, but the organism has no action on lactose and forms no gas in any sugar. Even though non-motile, this organism does not fall in the dysentary group or into the general group of enteric bacteria for it liquefies gelatin, does not ferment mannite, does not reduce nitrate and gives a negative methyl red test. The frequency with which this organism occurs in both the normal and infected female G-U tract should be emphasized.

Other bacteria found less frequently in the female G-U tract include coliforms; long, slender Gram positive rods (probably *Loctobacilli*, Doderlein's bacillus); Gram positive sporeformers; and micrococci in tetrads and cubes of eight.

The use of the dye indicator, para-aminodimethylaniline monohydrochloride is by no means specific

Table I. Comparison of the use of chocolate agar and Peizer's medium in the detection of gonorrhea in the female.

Female Cases	Clinical Symptoms	Gonococci in Gram stained smear		Growth of cultures from G-U tract on <i>chocolate agar</i>	
		GC Colonies ^a	Other Types	Dye	Oxidation
#3/4	marked	0	0	Gram + rods	3+
#5/6	marked	0	0	Gram + strep	—
				coliforms	—
				G-coccoid-bacilli	—
#7/8	marked	0	0	G-diphtheroids	—
				G + diphtheroids	4+
				coliforms	—
				G-coccoid bacilli	—
#9/10	marked	+	0	staph	—
				coliforms	—
#11/12	marked endocervicitis	+	+	strep	—
				large G-diphtheroids	4+
				small G-coccoid rods	—
#13/14	grade 3 endocervicitis	0	0	staph	—
				small G-diphtheroids	4+
#15/16	suspicious	+	+	G-diphtheroids	3+
				staph	—
#17/18	none	0	0	G-diphtheroids	3+
				staph	—
#19/20	marked	+	+	H. Staph albus	—
				G + diphtheroids	3+
				coliforms	—
#21/22	suspicious	0	0	G-diphtheroids	3+
				staph	—
#23/24	marked	0	0	G-diphtheroids	3+
				small G-coccoid rods	—
				Gram + rods	4+
#25/26	suspicious	0	0	G-diphtheroids	3+
				small G-coccoid rods	—
				staph	—
#27/28	suspicious	+	0	G-diphtheroids	3+
				staph	—

^aIndicated by dye-oxidation test and by Gram stain directly from suspected colony.

Table II. Use of Nile blue chocolate agar as a selective medium in detection of gonorrhea in the female.

Female Cases	Gonococci in Gram-stained smears	Chocolate agar GC Colonies ^o	GC Colonies	Chocolate agar with Nile blue added in 1/44,000, final concn. Relative amount ^{o o} bacterial growth
#1	—	—	—	50% less
#2	0	0	0	50% less
#3	0	0	0	about same
#4	0	0	0	25% less
#5	0	0	0	about same
#6	0	0	0	50% less
#7	0	0	0	50% less
#8	0	0	0	25% less
#9	0	0	0	about same
#10	0	0	0	about same

^oIndicated by dye-Oxidation test and by Gram stain directly from suspected colony.

^{o o}Dominant types of bacteria appearing on the plates.

1. Diptheroids (invariably oxidize the dye)

2. Staphylococcus albus (no action on the dye)

3. Gram negative small coccoid bacilli (see Table IV—no action on dye)

4. Coliforms (no action on dye)

5. Gram positive spore-formers (oxidize dye).

Table III. Growth of the G-U flora from suspicious female cases of gonorrhea on various selective media.

Female Cases	Brilliant green agar	Nile blue agar	Malachite green agar	Gentian violet agar	Chocolate agar	Plasma-proteose agar
#1	C— ^o	Dd+ A— B+	B+	C—	A— B+	A— B+
#2	C—	C— E—	Da+ F— E—	O	A— B+	A— B+ Dd+
#3	O	A— Da+ F+	O	O	A— B+ C+	B+ C— Dc+
#4	C—	A— B+ Dc+	Dc+	O	B+ C— Da—	A— B+ Dd+
#5	O	A— B+	O	O	B+ Dd+	A— B+
#6	O	A— B+ B—	O	O	A— B+ Dd—	A— B+
#7	O	G+	O	G+	G+	G+

in detecting colonies of *Neisseria*, especially *Neisseria gonorrhoeae*. While it is true that gonococcus colonies give an immediate and intense purple coloration, the colonies of other species of bacteria also oxidize the dye and occasionally with the same immediate and intense coloration. Usually, however, oxidation of the dye by other species of bacteria takes longer and the color is not as intense. With only a few exceptions the many strains of diptheroids encountered in this work gave more or less intense oxidation of the dye indicator. Invariably Gram positive spore-formers oxidize the dye, but oxidation by these organisms is usually slow requiring 2-3 minutes and the color that develops is a faded purple or blue. Occasionally coliforms have oxidized the dye; however, staphylococci and the above mentioned Gram negative coccoid rod have no action on the dye.

In working with the gonococcus, one will appreciate the patience required. The organism is extremely fastidious and delicate. Other strains of the organism, even though transferred frequently under optimum conditions to appropriate medium, will not grow again. Occasionally what seems like a luxuriant-growing culture, freshly isolated on artificial medium will spontaneously become non-viable on transfer, even when the transfer is made soon after growth has appeared on the parent medium. Some isolations of the organism on appropriate artificial medium, for no obvious or apparent reason, readily revert to the rough atypical phase of growth. These facts seem paradoxical in view of the facility with which infection occurs and is maintained in the human being; however, it is not unreasonable to suppose that certain strains of the organism as occurring in the human body are possessed with similar peculiarities which confound diagnosis. The factors alluded to account in part at least for the seemingly unexplainable discrepancies that are bound to appear in any research involving the gonococcus.

CONCLUSION

1. Chocolate agar, to which is added 0.5% starch and nile blue A, appears to be as good if not better in the inhibition of contaminating bacteria in the flora of the female G-U tract than Peizer's medium, which is very time-consuming in preparation.

2. The gonococcus is not inhibited by the concentration of nile blue A employed in these studies. This is evidenced by comparisons of growth of the same amount of inoculum on ordinary chocolate agar.

3. Use of other dyes as inhibitors in the concentrations employed did not yield any significant advantage over the use of nile blue A chocolate agar. While it is true that there was marked inhibition of contaminants on all of these media, the growth of the gonococcus also was affected adversely; the gonococcus did not grow at all on brilliant green agar and on malachite green agar, and while it did appear on gentian violet agar and on nile blue agar with a high concentration of the dye, the colonies were not typical and the cell morphology was greatly distorted, resulting in difficult identification by the usual Gram

staining procedure.

4. The groups of bacteria most commonly found in the female G-U tract were found to include the following:

(1) Diptheroids. (Many species were evidenced by differences in cell morphology and staining).

(2) Staphylococci.

(3) Gram-positive rods (both spore-formers and the aciduric lactobacillus organisms).

(4) Small gram-negative coccoid bacilli, as yet unreported.

(5) Coliforms.

5. The O-R dye solution was oxidized intensely and immediately by gonococcus colonies; many other species of bacteria including the diptheroid group and Gram-positive spore-formers also oxidized the dye, but usually not as intensely nor as immediately as did the gonococcus. Staphylococci, coliforms and Gram-negative coccoid bacilli had no action on the dye.

6. Attention is called to the isolation of a gram negative non-lactosefermenting small coccoid rod found commonly in the female G-U tract, which has not been reported. Some of the cells of this species in mixed culture, as in a vaginal smear are indistinguishable from the GC organism morphologically and are probably responsible for many false positive results on diagnosis of the female gonorrhea; however, this saprophytic organism never occurs intracellularly in pus cells. In pure culture in addition to the pairs of bean-shaped coccoid cells, very small rods in pairs and occurring singly are also observed.

*The following legend indicates the types of bacteria represented by the letters above. The positive and negative signs following the letter indicate whether or not the bacterial species oxidized the dye-indicator:

- A. Staphylococcus
- B. Gram-positive spore-former
- C. coliforms
- Da. small G—diptheroids
- Db. large G—diptheroids
- Dc. small plump G—Diptheroids
- Dd. large G—diptheroids
- E. Small G—coccoid-bacillus (see Table IV)
- F. streptococcus
- G. gonococcus
- O. no growth appearing on the medium.

Table IV. Characteristics of an unreported species of bacteria commonly occurring and apparently a normal saprophyte in the female genito-urinary tract.

Morphology:

Small coccoid Gram negative rod

Size: about 0.6 U in diameter or 0.8-1U long

Arrangement: Appears in pairs and singly resembling the GC organisms remarkably; however, examination of a Gram-stained pure culture will show some of the cells elongated into very short rods.

No spores formed.

Non-motile.

No capsule.

Culture Characteristics:

Colonies form on plain agar readily and grow well on media containing various inhibitor dyes. Colonies are fairly large and butyrous.

Fermentation reactions: (No gas is formed in any carbohydrates broth)

dextrose	A	dulcitol	O
lactose	O	sucrose	O
xylose	A	maltose	O
mannite	O	adonite	O
abartinose	A	inositol	O

(slow, 3 days)

Special studies:

Gelatin—liquefied after 5-6 days, not within 3 days

Litmus milk—no action in 3-5 days; then slow acid curd develops.

Koser's citrate—heavy growth.

Urea broth—no growth.

Indole production—none.

Nitrate reduction—none.

Methyl red test—negative.

Oxidation of para dimethylaniline-monohydrochloride—none.

Growth on SS agar—luxuriant colorless colonies formed.

With the foregoing I have arrived at some facts concerning the diagnosis of gonorrhea. Workers are continuing their search to improve the media and to provide a method for shipping specimens. Cystine monohydrochloride and hydrothricin are the new ingredients which in the last few weeks has been reported to significantly inhibit contaminants. Others are approaching the problem differently and are trying to determine more fully the nutritional requirements of the gonococcus. With attempts at differentiation, there should follow correlation between types and chemoresistance. The goal is in site but we are not quite there; it will be realized when all practitioners are able to send satisfactory specimens to the laboratory for diagnosis and, in follow-ups, to de-

termine cure.

Until we arrive at this goal it is better to treat when there is only suspicion and treat beyond the end which usually eradicates the organism. There are those who consider that many "sulfa-resistant" strains of bacteria have been made so because of sub-effective doses of the sulfonamides. There are indications that 200,000 units of penicillin are desirable. When cure is not effective by chemotherapy, then one of the various schemes of fever therapy should be employed. With full utilization of these facts, this disease should become of insignificant incidence.

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COL. OLIN CHAMBERLAIN

Bushnell General Hospital, Brigham City, Utah—Promotion to Colonel of Olin B. Chamberlain of Charleston, S. C., and chief of the 813-bed neuropsychiatric service at this hospital was announced by Col. Robert M. Hardaway, commanding officer.

Colonel Chamberlain, who has been chief of the N. P. service at Bushnell since its inception in February, 1944, was associate professor of medicine in charge of neuropsychiatry at the medical college of South Carolina, and was a visiting physician at the school's Roper Hospital before entering the Army as a Major in June, 1942.

The new colonel is married, and with his wife is at present making his home in Brigham City, Utah, near Bushnell General Hospital. The Chamberlain's son, Olin B. Chamberlain, Jr., who has been discharged from the air corps, is now living at the family home at 48 South Battery St., Charleston.

Colonel Chamberlain was assigned to duty at Bushnell in September, 1942 when he assumed charge of the neuropsychiatric section which then consisted of two ward buildings operated under direction of the medical service.

In the spring of 1943 six additional ward buildings plus necessary administration, recreation and mess units were constructed and the following February the N. P. section was enlarged into a full service.

After receiving his medical degree from the South Carolina Medical College, Col. Chamberlain took his residency at the Philadelphia General Hospital, and then did post graduate work at the Queen's Square Hospital, London, England, and the Harvard Medical School.

He is a member of the American Medical Association, the Association for Research in Nervous and Mental diseases, the American Psychiatric Association and Phi Chi Fraternity.

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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

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AUGUST, 1945

MEDICAL COLLEGE CLINIC HOSPITAL

A statement was issued on July 5 which should bring joy to the heart of every physician in the state. It was a joint statement of a plan for the proposed Medical College Clinic Hospital which had been approved by the Medical Society of South Carolina (i. e. the Charleston County Medical Society) which is the trustee of Roper Hospital, and the faculty and Board of Trustees of the Medical College. It brings to an end the purported disagreements which had arisen between the Commissioners of Roper Hospital and the Medical College — disagreements which had been played up in the press and which had been hurled back and forth in the halls of the General Assembly. "When the doctors can't agree among themselves, what do you expect us to do?" had been a question asked by many laymen.

It is our sincere hope that the broadcasting of this statement will show the public that the spirit of reason and cooperation still rules in the actions of physicians and that there is now unity of purpose in the program for extending the facilities of the Medical College.

We urge that every member of our Association read with care the statement as it was released to the press by Dr. Kenneth Lynch, Dean of the Medical College, and Dr. George McF. Mood, Chairman of the Commissioners of Roper Hospital;

"After extended survey of the needs, aims, and opportunities of the Medical College of the State of South Carolina as the state's medical educational center and of the Roper Hospital as the community hospital of Charleston county, and from conferences between the board of commissioners of Roper Hospital and the dean of the Medical College, an agreement has been reached by which it is believed that the harmonious relations of the two institutions may not only be maintained but that they may be so closely integrated that their combined services so extended as to make possible the development of a greater medical educational and service center for the state and a complete medical service for the community.

"This agreement has been adopted by the Medical Society of South Carolina (Charleston county), which is the trustee of the Roper Hospital, and by the board

of trustees and faculty of the medical college.

"By the terms of the agreement, the present relations between Roper Hospital and the Medical College will be continued, the staff of the hospital will continue to be the faculty of the Medical College and the clinical facilities of the hospital will be available to the college for teaching purposes at all times.

"The Medical College will undertake to construct and operate a teaching clinic-hospital of about 325 beds, with quarters for intern and resident staff and for its pupil and resident nurses, and the board of commissioners will support this project.

"The staff of the proposed Medical College clinic-hospital will be of the closed type, restricted to the faculty.

"Its clientele will be of patients referred to the faculty by practitioners of medicine. They will be of three economic classes: (1) those who can pay part but not all of their cost of the hospital, (2) those who can pay for their hospital cost but no medical service fee, and (3) those who can pay the full hospital rate and, also, a professional fee.

"The full time medical staff of the hospital will be paid salaries fixed by the medical college authorities and a maximum salary will be set. Professional fees charged will not be lower than the average fee bill prevailing in this state.

"The medical college will not compete with Roper in accepting city or county appropriations for the care of charity patients. This includes such Roper Hospital services as for crippled children and cancer cases.

"In the cooperative development of the medical center, the medical college will undertake to provide such special services as may not come within Roper's scope and will depend upon Roper for the use of such services as it will naturally possess as a community hospital.

"Since the use of Roper as a teaching hospital entails a larger quarters in some departments, it will to the extent of its ability provide such necessary space in its new construction, while the medical college will supply the teaching equipment.

"The school of nursing will admit a sufficient number of students for both hospitals and each will be allotted its quota for housing and maintenance in accordance with its relative bed capacity. The student nurses will serve through both hospitals and under one

faculty organization. Their scholastic curriculum will be carried out in the medical college laboratories and class rooms. A joint diploma will be issued to those who graduate.

"Likewise, interns of the two hospitals and resident physicians in training will be in a combined organization and under one physician-in-chief and one surgeon-in-chief. Each hospital will house and furnish maintenance to its allotment of this resident medical staff.

"The Medical College will continue to furnish complete medical laboratory service to Roper, as has been the case for several years.

"The x-ray, electrocardiographic and metabolism services of each hospital will be entirely under its own control.

"The chairman of the board of commissioners of the hospital and the dean of the medical college have been authorized by the organizations which they respectively serve to make this joint statement, in order that the public may be informed as to the status of the relations between these institutions and of their purpose to coordinate their plans of expansion in such a way as to develop as one great medical center.

"It is our sincere belief that in cooperative effort these two institutions may now have the full opportunity for which they have labored together for almost one hundred years. It is our earnest hope that all of the interests concerned in their advancement may join in assuring their full success."

A FOURTEEN POINT PROGRAM

A fourteen point program was recently adopted by the Council on Medical Care and Public Service and by the Board of Trustees of the American Medical Association. It was released to the press for publication on July 19 and was given prominent notice in many of our state papers. (See page 204).

We hasten to congratulate the Council and the Board of Trustees in this progressive and forward-looking step which has been made. We have felt that for too long, in the eyes of the public, the American Medical Association has been noted for its progressive work in the field of science and for its sluggish activities in the broad field of medical social welfare. The public relations of the average physician in this country is good, but the public relations of physicians as a whole is far from what it should and could be. All too frequently the public has known what medical associations—and particularly the American Medical Association—were opposed to, but the public did not know what the associations were for. This Fourteen Point Program should do much to clear this misunderstanding.

Since the South Carolina Medical Association adopted a Ten Point Program one year ago, and since it is highly probable that our Ten Point Program was the stimulus which led to the Fourteen Point Program of the American Medical Association, we have been studying the newer Program with considerable

interest and have been comparing it with our own.

There is a marked similarity between the two programs if one will bear in mind that one is aimed at the national level and the other at a state level. The A. M. A. Program calls for "extending to all people in all communities the best medical care," and the S. C. Program declares as its purpose "to make available to all of the people of the State good medical and hospital care at prices they can afford to pay." Each Program calls for study and surveys regarding availability and need for medical care, for the adoption of special plans for the care of the indigent, for increased hospital and sickness insurance on a voluntary basis, for the promotion of medical education, and for the education of the public.

As we have read and studied the A. M. A. Program we are highly pleased with what is included but we are disappointed with something which is not included. The first point in our own Program is entitled Cooperation, and reads, "To promote closer cooperation and better understanding between all groups and individuals concerned with providing and improving medical care for the people of South Carolina." We regret that we are unable to find any such point in the Fourteen Point Program of the A. M. A.

As we have attempted to study the broad field of medical care in its social implications, as we have talked to men within and without the medical profession, we are convinced that no physician and that no medical organization is in a position to say what shall or what shall not be done. There are many others who are vitally concerned with medical care and these must be consulted and these must be made co-workers in any program which we attempt. Then and only then can we expect to attain the ultimate goal—the best possible medical care to all of the people at a price which can be paid. It is our hope, therefore, that the next edition of the Fourteen Point Program will include a strong statement on cooperation.

CONGRATULATIONS, GREENVILLE

The Greenville County Medical Society is to be highly commended for its plan to establish a \$100,000 Medical Foundation. According to Dr. Jack D. Parker, President of the Society, the purpose of the trust which will be called the "Medical Foundation" is "to establish a fund, the proceeds of which shall be used solely for scientific, educational and charitable purposes, including the promotion of the science of medicine, assisting medical students, the establishment of a medical library and the construction of a building for such purpose or purposes."

One hundred thousand dollars is the ultimate goal and several thousands have already been subscribed and collected.

It is the hope of the Society to fit the Foundation into the life of the community as it carries on its objective of fostering medical progress. There will be no immediate building program but this will be

started as soon as the Foundation's financial condition permits.

Other communities in the state will be watching Greenville with admiration as she launches forth on this courageous program. The Journal congratulates the physicians of Greenville County and their leader, Dr. Jack D. Parker, for what they are attempting and wishes for them great success in their undertaking.

PRESIDENT'S MESSAGE FOR AUGUST

The war situation is such that any plans with regard to a meeting of the House of Delegates of the Association must be held in abeyance. For that reason county societies should be more active than ever, as should our district societies. Any member of the Association who knows of any particular problem which should be studied or dealt with by the State Association should send this information to the Chairman of Council or to me immediately so that it can be given careful consideration.

In the last NEWS LETTER from the Council on Medical Service and Public Relations of the American Medical Association there are certain pertinent paragraphs which I am passing on to our members for careful reading.

No Summer Doldrums

There will be no summer doldrums this year for economics have a full quota of work on hand if their committees of state and local medical societies. Though many societies will suspend regular meetings during July and August, indications are that committees considering the various phases of medical economic have a full quota of work on hand if their reports are to be ready for presentation to their fellow members come September.

Three problems pressing for attention and early action are:

1. Return of veteran medical officers to private practice as soon as military necessity will permit.
2. Development and expansion of prepayment vol-

untary medical insurance plans.

3. Thorough study and analysis of Wagner-Murray-Dingell bills, S. 1050 and H. R. 3293. This year's measures are longer, more complex and far reaching than ever before.

Regional Conferences

In order to develop specific details of the program, the Council on Medical Service and Public Relations will continue regional conferences this fall. The number and nature of these meetings have yet to be outlined. Suggestions will be appreciated.

Information Pamphlet for Medical Officers

An information pamphlet for medical officers has been prepared by the Bureau of Information of the American Medical Association. This contains factual data about residencies, internships, establishing a practice, licensure, and the G. I. Bill as it pertains to physicians. This pamphlet will be available soon. It is informative and should be of real help to medical officers by telling them of present opportunities and describing facilities for further education in civilian institutions.

Mackinac Conference

Although often shoved off the front page by the consideration by the Senate of the World Charter, actions taken by the National Governors' Conference at Mackinac Island on July 1-4 will not be overlooked. Restoration to the forty-eight states when peace comes of powers taken by the Federal Government during the war was the theme of the meeting. A test case in governmental control probably will come when President Truman considers the return to the States of the unemployment service. Originally control of the service was placed in the hands of the various states. After Pearl Harbor it was removed by executive order from the states to the Federal Government as an emergency war measure. Now many governors are asking that it be returned to the states. What President Truman does about this will give a hint as to what may be expected in other matters involving state and federal control.

PIEDMONT POST GRADUATE ASSEMBLY and FOURTH DISTRICT MEDICAL SOCIETY

Anderson County Hospital — New Nurses Home
Lecture Room

September 18, 1945, 2:30 P. M.

Officers of Assembly

President—Capt. John F. Rainey, Wakeman General Hospital, Camp Atterbury, Indiana.

Exec. V. Pres.—J. R. Young, M.D., Anderson, S. C.

Sec.-Treas.—A. L. Smethers, M.D., Anderson, S. C.

PROGRAM

2:30—Management of Some Common Skin Diseases and Presentation of Clinical Cases—A Benson Cannon, M.D., New York, N. Y.

3:30—The Army's Appraisal and Management of Battle Fatigue—Col. C. T. Young, Camp Atterbury, Indiana.

4:00—Management of Melanoma—J. Elliott Scarborough, M.D., Atlanta, Ga.

4:30—Orthopedic Problems Which the General Surgeon and Family Doctor Should Handle—O. L. Miller, M.D., Charlotte, N. C.

5:00—Present Day Treatment of Primary Syphilis—A. Benson Cannon, M.D., New York, N. Y.

Evening Session — Calhoun Hotel,

Banquet 8 P. M.

J. Decherd Guess, M.D., Toastmaster

Some General Remarks on Cancer—J. Elliott Scarborough, M.D., Atlanta, Ga.

Biographical Sketch—"Dr. Oliver M. Doyle"—O. L. Miller, M.D., Charlotte, N. C.

Registration of \$5.00 which will include the banquet

CONSTRUCTIVE PROGRAM FOR MEDICAL CARE

AMERICAN MEDICAL ASSOCIATION

This platform was adopted by the Council on Medical Service and Public Relations and the Board of Trustees of the American Medical Association on June 22, 1945.

Preamble

The physicians of the United States are interested in extending to all people in all communities the best possible medical care. The Constitution of the United States, the Bill of Rights and the "American Way of Life" are diametrically opposed to regimentation or any form of totalitarianism. According to available evidence in surveys, most of the American people are not interested in testing in the United States experiments in medical care which have already failed in regimented countries.

The physicians of the United States, through the American Medical Association, have stressed repeatedly the necessity for extending to all corners of this great country the availability of aids for diagnosis and treatment, so that dependency will be minimized and independence will be stimulated. American private enterprise has won and is winning the greatest war in the world's history. Private enterprise and initiative manifested through research may conquer cancer, arthritis and other as yet unconquered scourges of humankind. Science, as history well demonstrates, prospers best when free and unshackled.

Program

The physicians represented by the American Medical Association propose the following constructive program for the extension of improved health and medical care to all the people:

1. Sustained production leading to better living conditions with improved housing, nutrition and sanitation which are fundamental to good health; we support progressive action toward achieving these objectives:

2. An extended program of disease prevention with the development or extension of organizations for public health service so that every part of our country will have such service, as rapidly as adequate personnel can be trained.

3. Increased hospitalization insurance on a voluntary basis.

4. The development in or extension to all localities of voluntary sickness insurance plans and provision for the extension of these plans to the needy under the principles already established by the American Medical Association.

5. The provision of hospitalization and medical care to the indigent by local authorities under voluntary hospital and sickness insurance plans.

6. A survey of each state by qualified individuals and agencies to establish the need for additional medical care.

7. Federal aid to states where definite need is demonstrated, to be administered by the proper local agencies of the states involved with the help and advice of the medical profession.

8. Extension of information on these plans to all the people with recognition that such voluntary programs need not involve increased taxation.

9. A continuous survey of all voluntary plans for hospitalization and illness to determine their adequacy in meeting needs and maintaining continuous improvement in quality of medical service.

10. Discharge of physicians from the armed services as rapidly as is consistent with the war effort in order to facilitate redistribution and relocation of physicians in areas needing physicians.

11. Increased availability of medical education to young men and women to provide a greater number of physicians for rural areas.

12. Postponement of consideration of revolutionary changes while 60,000 medical men are in the service voluntarily and while 12,000,000 men and women are in uniform to preserve the American democratic system of government.

13. Adoption of federal legislation to provide for adjustments in draft regulation which will permit students to prepare for and continue the study of medicine.

14. Study of postwar medical personnel requirements with special reference to the needs of the veterans' hospitals, the regular army, navy and United States Public Health Service.

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**Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

A. M. A. BULLETIN No. 15

By this time you have received a copy of Senator Wagner's Address made on the occasion of his introducing to the Senate his new Social Security Bill, S. 1050. If you have not received a copy of the Bill and would like to have a copy to read, we shall be glad to send it to you upon request.

The Senator has collected almost all of the social security legislation that has been proposed into this one Bill. It would be wise, therefore, for everyone to read the Bill carefully before deciding upon its merit. The compulsory insurance feature, of course, is about as objectionable as it was in the previous Bill, although some other sections in the Bill may not be objectionable. The provision in the early part of the Bill for the erection of hospitals differs significantly from the Hill-Burton Hospital Bill.

It is altogether possible that the Senate Finance Committee to which the Bill has been referred may hold hearings in the fall.

S. 960 by Mr. Hill of Alabama, May 3.

A Bill to facilitate employment of necessary personnel in the Veterans' Administration. Referred to Committee on Expenditures in the Executive Departments.

S. 1021 by Mr. Stewart of Tennessee, May 17.

A Bill to amend the Social Security Act, as amended, for the purpose of enabling self-employed individuals to secure coverage under the old-age and survivors insurance provisions of such Act.

Referred to Committee on Finance.

S. 1042 by Mr. Bailey of North Carolina, May 24.

A Bill to amend the Federal Food, Drug, and Cosmetic Act of June 25, 1938, as amended, by providing for the certification of batches of drugs composed wholly or partly of any kind of penicillin or any derivative thereof, and for other purposes.

Referred to Committee on Commerce.

S. 1050 by Mr. Wagner of New York, May 24.

A Bill to provide for the national security, health, and public welfare.

Referred to Committee on Finance.

S. 1079 by Mr. Johnson of Colorado, June 1.

A Bill to establish a Department or Bureau of Medicine and Surgery in the Veterans' Administration.

Referred to Committee on Finance.

Comment: Identical with H. R. 3310.

S. 1099 by Mr. Aiken of Vermont, June 4.

A Bill to amend the Public Health Service Act so as to provide assistance to States in developing and maintaining dental health programs, and for other purposes.

Referred to Committee on Education and Labor.

Comment: Identical with H. R. 3412 and 3414.

H. R. 525 by Mrs. Norton of New Jersey, January 3.

A Bill to provide for cooperation with State agencies administering labor laws in establishing and maintaining safe and proper working conditions in industry and in the preparation, promulgation, and enforcement of regulations to control industrial health hazards.

Referred to Committee on Labor.

H. R. 2477 by Mr. Fenton of Pennsylvania, March 5.

A Bill to give recognition to the noncombatant services under enemy fire performed by officers and enlisted men of the Medical Corps of the Army.

Referred to Committee on Military Affairs.

Comment: Amended and passed out by Committee on June 5th. Placed on House Consent Union Committee Calendar. The amendment deleted the entire original bill and added in part: "That during the present war and for six months thereafter any enlisted man of the Army who is entitled under regulations prescribed by the Secretary of War, to wear the medical badge shall be paid an additional compensation at the rate of \$10.00 per month."

H. R. 3119 by Mr. Rankin of Mississippi, May 3.

A Bill to amend parts VII and VIII of Veterans Regulation No. 1(a), as amended, to liberalize and clarify vocational rehabilitation and education and training laws administered by the Veterans' Administration, and for other purposes.

Referred to Committee on World War Veterans' Legislation.

Comment: Introduced by Mr. Rankin at the request of a veterans' organization.

H. R. 3120 by Mr. Weiss of Pennsylvania, May 3.

A Bill to prevent discrimination against veterans by use of the physical examination to disqualify them for their old jobs.

Referred to Committee on Military Affairs.

H. R. 3293 by Mr. Dingell of Michigan, May 24.

A Bill to provide for the national security, health and public welfare.

Referred to Committee on Ways and Means.

Comment: Identical with S. 1050.

H. R. 3310 by Mr. Rankin of Mississippi, May 25.

A Bill to establish a Department or Bureau of Medicine and Surgery in the Veterans' Administration.

Referred to Committee on World War Veterans' Legislation.

Comment: Identical with S. 1079.

H. R. 3317 by Mrs. Rogers of Massachusetts, May 25.

A Bill to establish a Bureau of Medicine and Surgery in the Veterans' Administration. Referred to Committee on World War Veterans' Legislation.

H. R. 3332 by Mr. Barry of New York, May 28.

A Bill to eliminate financial inability to defray expense of hospital treatment or domiciliary care as a prerequisite to obtaining such treatment or care in a Veterans' Administration facility to provide for transportation to such facilities for such treatment or care, and for other purposes.

Referred to Committee on World War Veterans' Legislation.

H. R. 3350 by Mr. Judd of Minnesota, May 29.

A Bill to authorize the release of persons from active military service, and the deferment of persons from military service, in order to aid in making possible the education and training of physicians and dentists to meet essential needs.

Referred to Committee on Military Affairs.

Comment: Identical with S. 637.

ACTION ON BILLS:

H. R. 525 — Mrs. Norton was reported out of Committee on May 29th.

H. J. Res. 212 — Passed by the House on June 6th and the Senate on June 8th. Among other appropriations it carries \$2,200,000, an additional amount for 1945, the fiscal year, under the appropriation entitled "Grants to States for Emergency Maternity and Infant Care (National Defense)." The previous appropriation for the current fiscal year was \$42,800,000 which is insufficient to meet the payments through June.

The House Military Affairs Committee authorized Chairman May to introduce and order reported a clean bill, H. R. 3440, in lieu of H. R. 2946, reported in Bulletin No. 13, providing for permanent programs of scientific research in the interest of national security.

Comment: Authorizes annual appropriations of \$8,000,000 and provides for periodic reports to Naval and Military Affairs Committees on the progress of the research program.

Respectfully submitted,
JOS. S. LAWRENCE
Council on Medical Services and Public Relations
Director, Washington Office.



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The Ten Point Program

M. L. MEADORS, EXECUTIVE DIRECTOR AND COUNSEL

THE SURGEON GENERAL EXPRESSES VIEWS ON POST WAR PUBLIC HEALTH

In an address delivered at the dedication of the Health Institute, UAW, CIO, at Detroit in January, Surgeon General Thomas Parran outlined the projected scope of the rapidly developing program of public health. In view of his present official position and the greatly magnified importance it would assume under the terms of the Wagner-Murray-Dingell Bill, the views of the Surgeon General are of considerable interest and deserve attention. His address referred to above, is quoted in full in the Public Health Reports for April 27th. Among other things, he said:

"It is obvious that the financing of medical care of the individual, as a part of the program for total health care, should include some arrangement for prepayment. The occurrence of disease is sporadic. The heavy cost of catastrophic disease falls unpredictably and unevenly upon the population. For the individual family, I believe that these risks should be met on a national basis, either through insurance, or through public taxes, or, preferably through a combination of both. Social insurance thus can contribute to the advancement of national health by spreading the cost of illness and by providing the wage earner compensation in lieu of wages when he is ill and unable to earn.

"Social insurance in itself, however, no matter how inclusive, does not constitute a total health program, but is part of it and contributory to it. In the same way, better nutrition on a national basis is in the interest of national health. Slum clearance and the provision of decent, sanitary housing also is an important task for the nation, but this, too, is only one sector of a total health program. Finally, a high level of employment is necessary if we are to have a healthy nation."

Also: "It is urgent that, throughout the country, State by State, we put ourselves in a position to render the highest quality of health care which the people so earnestly desire. Indeed, if we have the vision to attain that goal, we must plan now to move forward on all health fronts and at the same time.

"We should not—indeed, we dare not—wait for the functioning of a health-insurance plan before starting the construction of hospitals and health centers, the training of health and medical personnel, and the expansion of existing health services. All of the measures for the prevention and cure of disease should fit together as a unit program. Central to the success of such a program are adequate facilities and health

manpower."

Concluding his address, Dr. Parran summarized the various elements of a proper system of public health as follows:

"(1) We should find the means to finance the costs of medical care for every individual, through tax-supported programs, health insurance, or a combination of both.

(2) Tax funds should be made available through grants-in-aid to the States for the construction of hospitals and health centers.

(3) To insure adequate numbers of health and medical personnel, tax funds should be made available for the expansion of professional education.

(4) We should provide for the application of all the knowledge we have to prevent disease, through full-time public health departments in every part of the country and the addition of such services as industrial hygiene, public health nursing, children's dentistry, mental hygiene, and nutrition.

(5) The Nation should continue to support and encourage both public and private research in the medical sciences through grants-in-aid to qualified institutions.

(6) We should meet the present deficiencies in the Nation's sanitary facilities through the construction of public water supplies, sewerage systems, and the like."

"BETTER MEDICAL CARE"

Without presuming as a layman, to comment thereon, we quote from the views of one doctor as expressed in the Pennsylvania Medical Journal's May editorial, who suggests that all the blame for the current disturbed situation may not lie with the politicians and social reformers:

"Progress is no doubt being made to integrate the practice of medicine with the needs of the times and to provide for 'nation-wide medical care for every person in the United States' to be paid for by a choice of methods. But, according to reports of the Health Program Conference in New York City in December and of a recent meeting sponsored by the National Physicians' Committee in Philadelphia, we as physicians seem to be interested at present in only part of the problem. At both meetings the only plans discussed were those for insurance, whereby the public will be better able to continue to pay for medical care as it is. No proposals were made that we make some changes in ourselves or in our methods of supplying medical care. In other words, we seem



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to be chiefly interested in changing something for the other fellow, so long as it doesn't affect us personally. In general, we have been persistently guilty of obstructing any plan which might change certain methods of practice for the better and have adopted a negative attitude as evidenced by such recent publications as "The Doctor Glares at State Medicine" or "What You Can Do to Defeat State Medicine." Worst of all are the undignified, unprofessional, petulant threats of active resistance adopted from trade union methods. It is a great misfortune that no real leader has emerged among physicians to lead us toward constructive evolutionary changes, and to have the lead taken from us, only temporarily we hope, by laymen.

"If we ourselves, singly or collectively, had arranged for the better distribution of better medical care many years ago, there would be no furore now for the socialization of medicine. Schemes for the establishment of group services or diagnostic clinics were, as a matter of fact, planned for by the Philadelphia County Medical Society only to be interrupted by the war, but we should at least continue to plan along these lines.

"In the meantime let us attempt to correct some evils and shortcomings of our own. Let us indulge in some searching self-criticism rather than in mutual admiration and self-complacency. We boast of the good health of the United States, yet we read that 40 percent of men of military age are physically or mentally unfit for military duty. There is a real need to change some of our methods and to abandon many traditional, habitual, outmoded, unnecessary expensive therapeutic procedures and operations, which in themselves contribute to the high cost of medical care."

"LAY EXECUTIVES IN MEDICINE"

In view of our direct personal interest in the subject, it is not surprising that our attention was attracted by the above title in the department "In and Out of Focus" in the April issue of the Medical Annals of the District of Columbia. The "Observer," as the author terms himself, points out that "although a comparatively new figure in the medical field, the lay executive in medicine seems to have established himself firmly. Among the positions he has filled are those of hospital administrator, business manager of clinics, of medical service and hospitalization plans, and executive officer of medical organizations." Stating that in the beginning there was considerable skepticism on the part of many physicians, the writer says that "when the layman proved himself competent for his task, skepticism gave way to approval." He continues:

"Your Observer believes it is fair to state that the societies who employ lay executives are more efficiently administered than those who do not. There are exceptions, of course, but this opinion has been corroborated by physicians familiar with the conduct of medical organizations.

"Lay executives of medical organizations are fully

cognizant of their limitations, some of them so much so they suffer from an inferiority complex. They have advantages, however, over a physician in a similar position. For example, their status in a medical organization is a neutral one. They are not in competition with other physicians so they can deal more objectively with matters which come before them. If competent, they can represent an organization more effectively in the civic life of the community. This is in part due to their training and the time which they can devote to such matters.

"Of course, lay executives are not uniformly successful. Some are better adapted to this type of work than others. There are mediocrities who do not do the job as well as they should, who lack initiative, drive and imagination. Capable or not, they have been intensely loyal to the organizations employing them. For the most part, they compare favorably with executives in other lines of work."

THE CORRECT VIEWPOINT

Under the title "The Legislature Acts Wisely," the New York State Journal of Medicine comments editorially in its May issue on the action of the New York State Legislature in refusing to pass a certain bill with respect to the requirements for license to practice chiropractic in the State of New York. Too often the question of licensing practitioners of chiropractic, naturopathy and related arts and sciences is pointed up as an issue between their devotees and the medical profession. To our way of thinking, the New York Journal correctly points out the item of first consideration and that it should take precedence over all else in the consideration of the requirements for the granting of such licenses.

"Many people take the attitude that in refusing to pass the chiropractic bill the legislators have done a favor for the doctors, protecting their economic interests or some equally irrelevant rot. Whereas, what the legislators have done, acting on the advice of scientists and educators, is to protect the public interest by insisting that only one standard of medical practice shall exist in this State. Any chiropractor or naturopath, or for that matter, any individual can practice medicine if he qualifies himself by required study and examination as the doctors do, in recognized institutions of learning. The legislators recognize this fact, and insist that anyone who proposes to occupy himself with the lives and health of the people of the State shall be properly qualified. It may be argued that this forces chiropractors to practice illegally, that they cannot be licensed. If they practice illegally, they do so knowingly, and the people of the State have the mechanism of the courts to deal with such a situation. This the legislators also realize.

"It is to be hoped that the doctors, scientists, and educators will support the legislators to the fullest extent in their consistent and well-fought battle to maintain the highest standards of medical practice for the people of this State."



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A FORETASTE?

Commenting upon the recommendations of the Steering Committee on Health Services, Advisory to the Childrens Bureau, printed in the March 3rd issue of the Journal of the American Medical Association, Northwest Medicine in its May issue quotes editorially the views of one prominent pediatrician:

"The suggestion appears that it will consume at least ten years, possibly all postwar years, to fully develop the program. That there is great merit in its plan there is no doubt. It could be of great value, although highly idealistic, but it maintains centralized control in the Childrens Bureau. A least seven times in this memorandum the Children's Bureau is urged to take charge of marked details, that the Bureau shall request more federal funds, give treatment service, supervise maternity care, assume Crippled Children's Program, seek elimination of court control that might interfere with Children's Bureau policy with children; again and again it is implied that the Children's Bureau shall dominate special details.

"Dr. Eliot can now say that the Children's Bureau has been urged to continue the EMIC Program in its widest ideas of expansion postwar. It would appear that the American public, the Academy of Pediatrics, and Medical Profession have been 'sold down the river.'

"This authority is proffered the Children's Bureau by a Committee, whose only power has been derived by virtue of having been appointed by the Children's Bureau. The foot to open the door for political medicine has made another inward move."

Is this an indication of the office that would be served by the Federal Advisory Council proposed in the new Wagner-Murray-Dingell Bill? That possibility should be carefully considered and squarely faced while the Bill is under discussion.

FLORIDA COMMENTS ON SENATOR PEPPER'S PROPOSALS

The Journal of the Florida Medical Association may be justified in looking with more sympathy or indulgence than others on the views of Senator Pepper; but the attitude expressed in the editorial in its May issue contains food for thought:

"We believe when a system is found that includes all of Senator Pepper's proposals it will meet with everybody's approval. Then how can such a thing be accomplished?"

"It can, we believe, be accomplished by an honest effort on the part of our leaders in the American Medical Association and in Congress, conferring together, to devise a workable plan that will safeguard the interests of both the public and organized medicine. There must be such a common ground. We need—all of us, the public and the profession alike—to be more unselfish in our desires; to think less of what our Government owes us and to think more of what we owe our Government.

"We wonder, seriously, if a system of compulsory insurance could be worked out that would cover completely all the people and still make no effort to regiment the medical profession. Why should any insurance make it necessary to change the method of the practice of medicine? Why should compulsory insurance make it necessary to regiment anyone?"

"We believe that with the proper thinking and the proper effort to cooperate one with the other that a satisfactory plan can be found."

CHANGE INEVITABLE

Commenting upon "The Changing Order," the Connecticut State Medical Journal in an editorial in the June, 1945 issue points out that before the war the development of specialization, hospital usage and precision diagnosis had changed the medical practice and that the whole pattern had so developed that ordinary sickness in many instances represented a financial disaster.

From this and other circumstances, the writer points out that two developments seem inevitable in the postwar years: "First, a development of medical practice toward group practice in close association with hospitals and laboratories; and secondly, a development along socio-economic lines in which the cost of sickness will be provided for by insurance methods either on the voluntary or on the compulsory basis. The necessity for the first change is being realized by the medical profession, for medical science of today demands the advantages to be gained by group endeavor, hospital facilities and readily available laboratory aids. Its finest development will come when all of us appreciate some of the inadequacies of individual competitive practice and look for ways in which to adapt practice to the newer environments. The second development requires a considerable change in the traditional thinking of the average physician. Never having had training in the new concepts of social science, he may not take kindly to the idea that practice will require radical changes in order to make it available to all people. Furthermore, it must be recognized that these changes must be guided within the profession and that only through proper organization can effectual controls be established. It is not a moment too soon to seriously consider these things, for already there are those who are interested in having the government change the practice of medicine and who are interesting the farmers, the labor groups, and the agitators in their schemes."

THE TREND TOWARD HEALTH INSURANCE

New York Medicine, the official publication of the Medical Society of the County of New York, in its issue of June 20th, gives some interesting figures on the increasing efforts to provide legislation looking toward health insurance, compulsory or otherwise:

"The Research Council for Economic Security has published a table showing the number of compulsory

health insurance bills introduced in various states over an eleven year period. The significant fact is shown that in the single year of 1945 up to date, there have been 34 such bills proposed in various state legislatures, whereas in the preceding ten years there was a total of only 66 similar measures introduced.

"This would seem to show a rising degree of

popular interest in the subject. Incidentally, of the 66 bills offered from 1935 through 1944, 22 or exactly one-third were introduced in the New York State Legislature. Our nearest competitor, Rhode Island, had a total of 9 bills offered in ten years. Of the 34 bills proposed in 1945, 11 appeared in California, 7 in Massachusetts and 5 in New York State."

PUBLIC HEALTH NEWS

S. C. PUBLIC HEALTH HOSPITAL TO BE OPERATED WITH USPHS FUNDS

\$30,000 to be Spent on Improvements in Near Future

Only Infectious Cases of Syphilis to be Accepted

Dr. Ben F. Wyman, State Health Officer, has announced that beginning July 1 the South Carolina Public Health Hospital, located on the Charleston highway 12 miles from Columbia, will receive all funds for carrying on its rapid treatment program for the control of venereal disease from the United States Public Health Service. Heretofore, the hospital has been operating with funds provided under the Lanham Act through the Federal Works Agency. Medical assistance and some nursing assistance were provided by the USPHS.

Under the new arrangement, Dr. Wyman said, the USPHS has been authorized by a special act of Congress to furnish all funds for the rapid treatment center, provided the physical property and all drugs used are furnished by the State. It is estimated that the cost of drugs for the fiscal year will be \$60,000.

After June 30 only infectious cases of syphilis will be admitted for treatment. No non-infectious cases of syphilis or cases of gonorrhea will be accepted. Except in extreme emergency cases, Dr. Wyman said, this ruling will be strictly adhered to. Each case applying for admission to the hospital will be individually passed on before being accepted for treatment.

The South Carolina Public Health Hospital, formerly known as the Sandhill Public Health Hospital, was the third treatment center established in the State under the war emergency venereal disease control program carried on by the State Board of Health in cooperation with the USPHS. The first treatment center was opened at the abandoned CCC Camp

near Goldville December 7, 1942, for the isolation and treatment of venereally infected colored women. The second was opened at the abandoned CCC Camp near Pontiac December 29, 1942, for white women patients.

On November 8, 1943, the white patients were transferred from the Pontiac hospital to what was then known as Camp Victory — which later became the Sandhill Public Health Hospital and is now the South Carolina Public Health Hospital—and two days later, November 10, 1943, the Goldville hospital was closed and all patients were transferred to Pontiac. On October 1, 1944, the Pontiac hospital was closed and all patients were transferred to the new Riverside Public Health Hospital, a modern brick building which had been constructed on the Broad River Road 8 miles from Columbia for rapid therapy treatment only.

Both the Pontiac and Goldville hospitals were closed on account of poor location, a lack of proper facilities, high administrative and maintenance costs, and the difficulty of keeping trained personnel.

Since February 7, 1945, when the Riverside Hospital was destroyed by fire, the South Carolina Public Health Hospital has been receiving all patients, both men and women, white and colored, who have been accepted for rapid therapy treatment.

Within a month, Dr. Wyman said, a \$30,000 renovation program will be commenced at the hospital by the Federal Works Agency. Improvements will include extra plumbing facilities, building of walkways between buildings, installation of electrical cooking equipment, painting, and other needed repairs.

The staff of the hospital is composed of the following: Major Ford Williams, Chief Medical Officer; Lieutenant Gordon Jones, Assistant Medical Officer; 19 registered nurses; laboratory technicians; record analysts and administrative workers. Mr. H. M. McElveen is Administrative Officer.

NEWS ITEMS

Dr. and Mrs. Wells Brabham of Orangeburg, announce the birth of a daughter, Mary Cleckley, on June 27th.

Dr. W. L. Pressly, Due West, has been appointed a member of the Council of the Southern Medical Association from South Carolina for a regular Council term of five years, beginning at the close of the annual meeting in November. Dr. Pressly succeeds Dr. J. Warren White, Greenville, whose term will expire at the close of the annual meeting in November and who, having served the constitutional limit, is not eligible for reappointment.

The Chester County Medical Society held its monthly meeting on Tuesday, June 12th at the Pryor Hospital. Dr. W. R. Wallace was in charge of the program. He had as his guest speaker his son, Dr. Furman Wallace, who made a very interesting slide talk on "Continuous spinal anesthesia."

Dr. Furman Wallace is a graduate of the South Carolina Medical College, Charleston, S. C. He interned at the Methodist Hospital at Indianapolis, Ind., for one year, then entered Roper Hospital in Charleston as resident in surgery for one year, then as assistant chief surgeon the second year, becoming chief resident and instructor in surgery his third year. He began practice in Spartanburg, S. C. on July 1st, and is affiliated with the Spartanburg General Hospital.

The First District Medical Society held its regular semiannual meeting in the Glass House Restaurant in Walterboro, June 21, 1945.

The meeting was called to order by the president, Dr. Black of Beaufort. Minutes of the previous meeting were read and approved. There being no new or old business to discuss, the scientific program was begun.

The first speaker of the evening was Dr. J. I. Waring of Charleston, S. C., who gave a very timely and instructive paper on "Dysentery in Children," stressing bed-rest, adequate fluids, and the sulfonamides as the three most important things to keep in mind. His paper was discussed at length by Dr. M. L.

Beach of Charleston.

Dr. W. R. Mead of Florence, was next on the program who gave a most interesting and timely discourse on "The Hazards of Bed Rest." He stressed in particular that long periods of bed rest following febrile diseases and operations was really more harmful than beneficial because of the fact that it was one of the most important predisposing factors favoring complications as pulmonary and cerebral embolus, congestive heart failure and coronary occlusion. In conclusion, he stated that we should attempt to get our patients up and exercising as soon as possible, and we would find that the percentage of the above complications would be surprisingly decreased.

His subject was discussed by Drs. Moore, Black, Hartzog, Remsen, Keck and Bailey. All of these were in complete accord with the speaker and complimented him very highly on his paper. Dr. Bailey mentioned it was the most sensible paper he had heard in years. Dr. Moore stated that he had been getting his patients up quite early for sometime but had not mentioned same, as he thought he would be severely criticized.

Dr. A. T. Moore of Columbia, then made a very interesting & practical talk on the "Fundamentals of Fracture Treatment & Low Back Pain," supplementing his talk with lantern slides which was most instructive, and was enjoyed by all. His subject was discussed by Drs. Walsh and Mead.

Capt. E. B. Keck, of Paris Island Naval Hospital was then introduced to the Society, and gave a very interesting talk on "The After Care of War Injuries," which was enjoyed by all.

Mr. Jack Meadows of Florence was present and made a few remarks about the "Blue Cross Program," calling attention to the fact that the bill was up before the Governor for his signature, and that the Governor was calling a committee meeting on the twenty-fifth to advise him what further action to take.

Dr. Beach made the motion, which was seconded by Dr. Chapman, that we send a telegram to Gov. Williams, urging his approval of the Blue Cross Bill. All was in favor of same, and the telegram worded as follows, was sent to the Governor:

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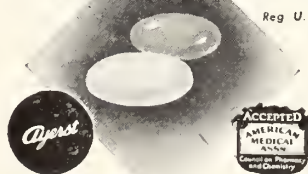
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The First District Medical Society, representing Allendale, Beaufort, Berkeley, Charleston, Clarendon, Colleton, Dorchester, Hampton, and Jasper Counties, in session yesterday at Walterboro adopted resolution respectfully urging your favorable action on the Blue Cross Bill at earliest possible time. The measure is of vital importance to the people of South Carolina and we are keenly interested in its early approval.

W. A. BLACK, President
1st. District Medical Society.

Among the South Carolina doctors attending the twenty-fifth annual session of the Southern Pediatric seminar at Saluda, N. C., from July 16 to July 28 are:

Dr. J. S. Palmer, Allendale; Dr. P. A. Brunson, Ridge Spring; Dr. M. S. Fender, Ehrhardt; Dr. H. S. Gilmore, Nichols; Dr. D. C. Griggs, Pageland; Dr. J. C. Hall, Gaffney; Dr. W. T. Hendrix, Spartanburg; Dr. J. A. Johnson, Marion; Dr. A. R. Johnston, St. George; Dr. D. S. Keisler, Leesville; Dr. G. L. Ken-

nedy, Ninety Six; Dr. Theodore Maddux, Union; Dr. R. E. Mason, Anderson; Dr. W. E. McCurry, Ridge Spring; Dr. E. H. Moore, Newberry; Dr. A. R. Nicholson, Edgefield; Dr. J. H. Porter, Andrews; Dr. J. O. Sanders, Anderson; Dr. F. K. Shealy, Clinton; Dr. L. C. Stukes, Summerton; Dr. J. V. Tate, Calhoun Falls; Dr. W. C. Whitesides, York; Dr. M. M. Young, Bishopville; Dr. T. G. Hall, Westminster; Dr. W. E. Whitely, Andrews; Dr. H. L. Peoples, Scotia; Dr. W. K. McGill, Clover; Dr. J. D. Thomas, Loris; Dr. J. A. Fort, North; Dr. R. E. Mays, Yemassee; Dr. Robert Black, Bamberg; Dr. A. L. Smathers, Anderson; Dr. W. W. Boyd, Spartanburg; Dr. W. A. Wall, Moncks Corner; Dr. S. A. Duncan, Benson; Dr. Duncan Pringle, Charleston; Dr. F. B. Johnson, Charleston; Dr. William Weston, Columbia; Dr. R. M. Pollitzer, Greenville; Dr. K. M. Lynch, Charleston; Dr. J. W. White, Greenville; Dr. M. W. Beach, Charleston; Dr. Julian Preece, Florence; Dr. George D. Johnson, Spartanburg; Dr. W. C. Mays, Fair Play.

AERA SAKOS

This column goes to print after a fairly long lay-off. The time seems to have approached when all the stories fit to tell are not fit to print. And that my friends, is a very bad situation. However, during the past several weeks a few of my well wishing friends have kindly supplied me with a few stories for this outstanding column.

Joe Cain of Mullins tells the story of the young couple who moved out on a farm. Wanting some young pigs they were told to bring their "girl" hog over to the neighbors and have her bred. So early one morning, the husband placed the sow in a wheelbarrow and rolled her over to the neighbors. Disappointed that no pigs were forthwithcoming the next morning, the husband again took the hog over to his neighbors. Finally, the third morning the wife went out to see the new pigs and reporting to her husband, she said, "There aren't any new pigs, but the hog is waiting in the wheelbarrow."

Then too, definitions, somewhat varied in color and accuracy are constantly kicked about, frinstance: Adolescence, the age when a girl's voice changes from "no" to "yes." Alimony, taxation without representation. Grapes, wine in pill form. Husband, a man of few words.

There are folks too that tell stories which are distracting and sometimes confusing as:

A centipede was happy quite,

Until a frog, in fun,

Said, "Pray, which leg comes after which?"

This raised her mind to such a pitch,
She lay distracted in a ditch,

Considering how to run.

Of course, there are the silly ones too:

There was a young person named Ned,

Who dined before going to bed,

On lobster and ham, and pickles and jam,

And when he awoke he was dead.

The story to end all hospital stories is told by an anonymous friend. Two hospital patients, bored and unable to secure playing cards, sneaked the diagnosis cards from a nurse's pocket as she went by. They started a game of draw poker with them. On the very first hand, after the draw, they bet high and outbid each other until all their money was on the table.

"Well, I guess I win," said one reaching out for the money. I've got three appendicitis and two gall stones."

"Just a minute," spoke up the other. "Not so fast. I've got four enemas."

"O. K." said the first. "You win the pot."

Since I reserve the right to like some of the stories that are printed in this column, I respectfully submit the following:

James Jones was a prominent member of a fraternal lodge. At the breakfast table he was relating to his wife an incident that occurred at the lodge the previous night. The president of the lodge offered a silk hat to the brother who could stand up and truthfully say that during his married life he had never kissed any woman but his own wife. "And would you believe it, Helen, no one stood up."

"James," his wife said, "Why didn't you stand up?" "Well," he replied, "I was going to, but you know I look like hell in a silk hat."

Pathological Conference, Medical College of the State of South Carolina

ABSTRACT NO. 440

Student B. F. Timmons, presenting:

Previous History: A 65 year old white woman entered the hospital August 21 having suddenly developed a severe cramping abdominal pain three days before. The pain began in the suprapubic region, shortly becoming generalized, and was accompanied by nausea and vomiting of white to greenish fluid. Bowels moved every other day, sometimes abated by laxatives, and the stools were yellow.

Four days prior to the above episode, the patient developed a sore throat accompanied by chills and fever, the latter persisting to the time of admission.

No history of previous digestive tract or urinary tract disturbances.

Physical Examination: B. P. 120/60. T. 99°. P. 90. R. 28. An acutely ill, dehydrated elderly white woman who was in considerable pain and appeared incoherent at times. The left tympanic membrane was red and there was injection of the naso-pharyngeal mucosa. The tongue was rough and dry. Examination revealed no changes in either lung. The heart was not enlarged and no murmurs or arrhythmias were noted. The abdomen was distended, tympanitic, and very tender. Peristalsis was not evident and the pain was generalized.

Laboratory 8-21: Blood — WBC 20,000. Hgb. 14 gms. PMNS 90% Lymph 6. Eos. 3. Urine — Sp. Gr. 1.023. Alb. 3 plus. WBC 10/HPF Casts. C. G. 4 plus. X-ray — left basal pleuritis. No evidence of obstruction.

8-22. Blood — sugar 109 mgm. Chlorides 453. Serum Proteins 7.07. Albumin 4.75.

8-23. Gastric analysis — color — black. Acid — 0. Blood 4 plus.

8-24. Blood Wassermann — negative. EKG — L. V. P. Tracing slightly suggests pulmonary embolus.

8-25 — Blood — WBC 21,500. PMN — 91%.

Course: With parenteral fluids, blood transfusions, and sodium sulfathiazole, the patients condition appeared to gradually improve. The temperature ranged from 98.8° to 104.2°, usually from 99.8° to 101°. Stools showed no evidence of blood. Wangenstein suction begun on 2nd day. On Aug. 29, a nurses note at 4:30 stated that the patient was cold and clammy, perspiring profusely, and had a weak pulse, the change having occurred rapidly. Following this, her course was downward and despite treatment, the patient expired Aug. 30th at 4:01 P. M.

Dr. F. E. Kredel, conducting: Mr. Latimer, give us your analysis of this case.

Student Latimer: I considered four entities in my differential diagnosis. These were: torsion of an ovarian cyst, mesenteric thrombosis, blood stream infection resulting from streptococcal infection of throat, and diverticulitis of colon. The absence of any sort of pelvic or abdominal mass is strongly against the first. There should have been blood in the stools with mesenteric thrombosis. Perhaps some of the blood in the stomach regurgitated up through the pylorus. If it was traumatic due to passage of the gastric tube it should be red. The location of the pain in the suprapubic area is somewhat lower than is usual with mesenteric thrombosis. I believe it possible for the peritoneum to be infected by way of the blood stream and the onset of sorethroat, chills and

fever before the abdominal symptoms is certainly striking. Diverticulitis of the colon should cause pain on the left side, but sometimes the rectosigmoid curves across to near the midline. I think mesenteric thrombosis most likely however.

Dr. Kredel: What are the most common causes of blood in the gastric contents?

Student Latimer: Ulcer and carcinoma. Perforation by either of these should produce a fulminating peritonitis and the pain would be situated higher in the abdomen.

Dr. Kredel: What do you think was the cause of death?

Student Latimer: Probably shock, due to rupture of gangrenous intestine. She probably had some degree of peritonitis all along, but a large segment of the intestine perforated terminally.

Dr. Kredel: Mr. Lyles, do you differ or have any other suggestions?

Student Lyles: I cannot make a definite diagnosis, but have narrowed the field down to a few. Diverticulitis with perforation is an excellent possibility. Diverticuli of the colon are more common in women and 5% of people over 40 have them. These statistics together with the lower abdominal pain and evidence of peritonitis support it.

Primary idiopathic peritonitis most often occurs in conjunction with streptococci infection, such as sore-throat or otitis media. The organisms are carried to the peritoneum by way of the blood stream. It usually runs a very rapidly fatal course and is very rare, particularly in a patient of this age.

Appendicitis must also be considered, although history is atypical. The appendix may be in various locations, however and thereby give variable pictures.

I feel that there is probably nothing wrong with the stomach. Although perforation of asymptomatic ulcers does occur, the pain should be in the epigastrium rather than the suprapubic region. The blood found by benzidine test in the gastric contents could have easily have been traumatic.

Dr. Kredel: Mr. Adams, can you offer any suggestions?

Student Adams: Nearly everyone has mentioned diverticulitis of colon, but no one has suggested perforation of a Meckel's diverticulum. This would more logically explain the location of the pain. A Meckel's diverticulum may be the site of an ulcer or may become inflamed in similar fashion to the appendix. The patient died of peritonitis. In a woman of this age many things occur that change the ordinary picture and I think appendicitis or Meckel's diverticulitis the best possibilities.

Dr. Kredel: Mr. Alexander, do you agree?

Student Alexander: I agree with much of the discussion. Volvulus of the colon might produce this picture, but as with mesenteric thrombosis, it should cause blood in stool.

Dr. Prioleau: There are comparatively few things that will give such a sudden onset, spreading peritonitis, and rapidly fatal course. Appendicitis has to be considered and can't be ruled out in a patient of this age. Diverticulitis is not as likely, for pain is not usually severe.

Dr. Boone: Everything points to a perforated viscus, but not stomach, for there is no acid. Appendicitis most likely statistically. Meckel's diverticulitis

more probable because of lower mid-line pain.

Dr. Lynch: *Final Pathological Diagnosis: Pancreatitis, Acute and Chronic with Acute Peritonitis.*

This is an acute abdominal catastrophe that is generally not diagnosed, indicating that it is very hard to diagnose. It may be considered in any abdominal catastrophe that has no other reasonable explanation. In many cases it makes little difference whether the diagnosis is made, but some cases are amenable to surgical treatment and of course other operable diseases must be differentiated. If this woman's condition had ever allowed surgery this was one case that may have been amenable to treatment, because the pancreatitis involved the tail. The story of involvement of the upper respiratory tract would certainly confuse the issue. I have never seen primary peritonitis except in infants and the usually pneumococci. It is really not "primary," but blood borne.

This is one of the cases of pancreatitis in which the background is well illustrated. Ducts may be ruptured due to obstruction, such as in the classical case of Opie in which a gallstone obstructed the ampulla of Vater. Too often this sort of condition is not found and other reasons must be sought. Among these other causes are: vascular closure with infarction and rupture of ducts, infection, obstruction of small ducts in pancreas due to squamous metaplasia of the epithelial linings. The latter is very conspicuous here with duct obstruction and dilatation.

DEATHS

Dr. C. T. J. Giles, 76, died at a hospital in Greenville on July 5, following several weeks of illness. Dr. Giles was graduated from the Medical College of the University of Georgia (1899) and began the practice of medicine at Piedmont. He stayed in Piedmont only a short time and then moved to Greenville where he had practiced forty-three years. Dr. Giles is survived by his widow, two daughters and one son.

Dr. James Everard Massey, 70, died July 14 after a long illness. An honor graduate of the Medical College of the State of South Carolina, Dr. Massey did postgraduate work in Baltimore, Philadelphia, New York and Boston before beginning his practice in Rock Hill. He was a member of the teaching staff of the York County hospital which was established during his service as senator from York County in 1939-1940, and was also a member of the Rock Hill Board of Health. Surviving are his widow, three sisters and a brother.

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The Journal of the South Carolina Medical Association

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SEP 20 1945

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BACKGROUND

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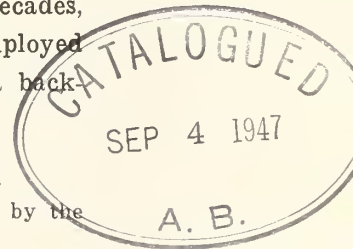
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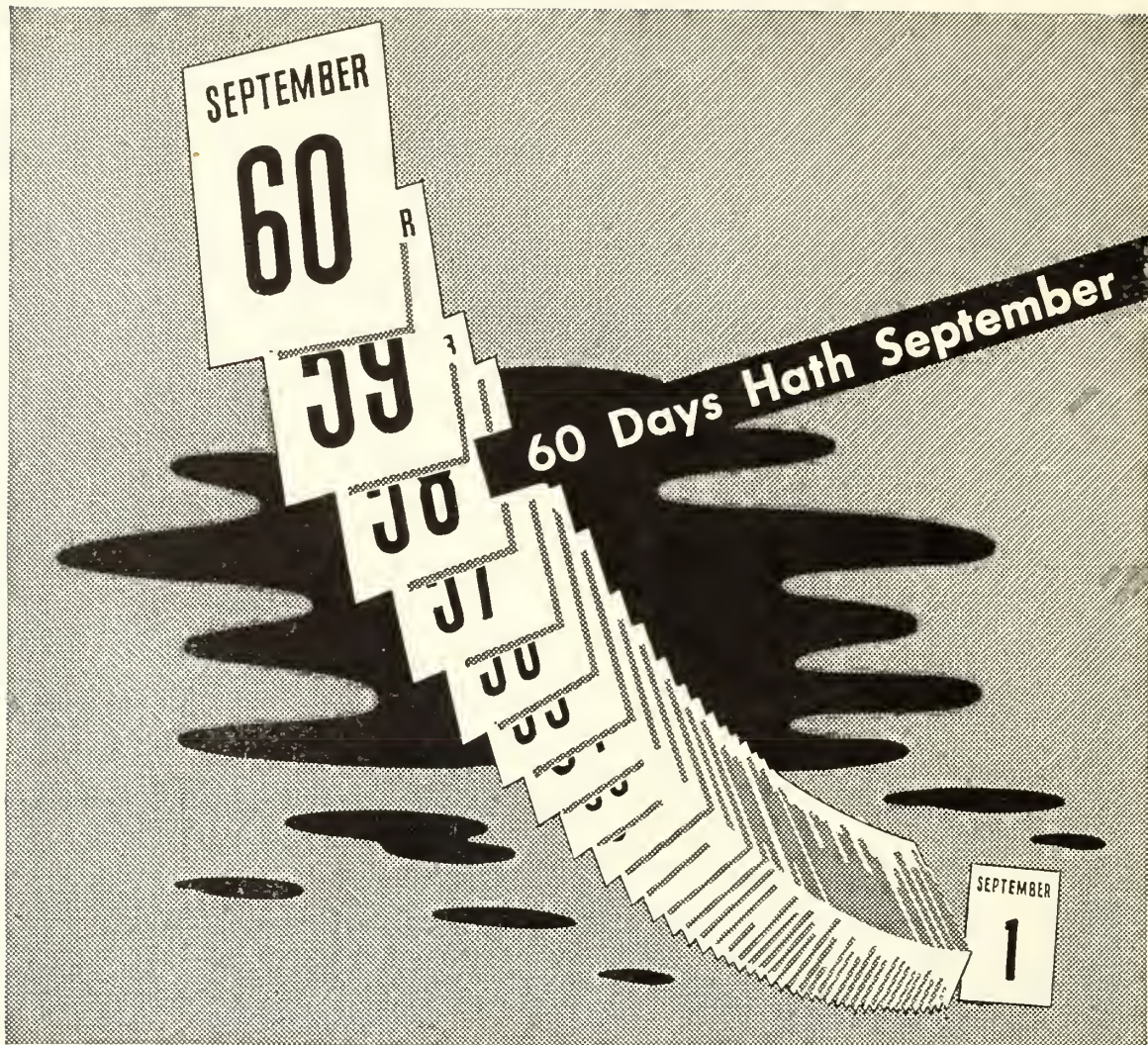
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 MORE THAN BEFORE — KEEP ON BUYING WAR BONDS

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The Relation Between Economic and Social Trends and the Practice of Medicine

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*The Bowman Gray School of Medicine of Wake Forest College
Winston-Salem, N. C.*

Dr. Lynch, fellow students, ladies and gentlemen:

I am grateful for the honor and pleasure this occasion brings to me. If I possessed the wisdom of Solomon and the eloquence of our late President, Franklin D. Roosevelt, I would not, by what I will say, impart to you more than a small share of what I myself will gain from this experience.

I love South Carolina. I am not like the native of Virginia who, when asked what he would be if he were not a Virginian, replied, "I'd be ashamed of myself." If I were not a North Carolinian, I would proudly choose to be a South Carolinian.

I have always had a great interest in this school. Early in my career as a pathologist before I had known him personally, your dean, Dr. Lynch, became one of my medical heroes. I have often tried to analyze the qualities which placed him so high in my gallery of distinguished medical men. I think they can be summed up in the statement: He is a balanced man, a teacher, investigator, and practitioner of medicine. Dr. Lynch has made great contributions to medical practice in South Carolina, and the medical profession in South Carolina has made equally great contributions to the history of this medical school. The worth of an institution can be measured by its contribution to the people it serves. Through the state-wide pathology service provided by Dr. Lynch, the doctor in South Carolina has an unusual opportunity to acquire scientific facts about his patient. When a doctor practicing in South Carolina, no matter where he received his diploma, refers to this school, he speaks of it as "our Medical School." Such a fine spirit of cooperation might well be envied by other medical schools.

You members of the graduating class, who will in a few moments receive the degree of Doctor of Medicine, arrive on the scene at a most opportune time.

Suppose we consider for a moment the type of medical practice that you will be doing when you step into professional harness, and its relation to economic and social trends. The symptoms and signs that make necessary changes in medical practice are real and plain. In our thinking let us not be radical or conservative, left-wing or right-wing, pro-socialized medicine or anti-socialized medicine. Let us disregard the advice of one of our popular songs and "mess with Mr. In-between." Let us recognize the fact that economic and social changes have taken place in this country since our fathers graduated from medical school, and that medical practice has no choice but to parallel changes in other phases of life.

This school was established in 1823, one hundred and twenty-two years ago. That is easily said. But is it easy to get a mental picture of South Carolina in that year? Can you visualize the great plantations, wealth and luxuries of the lowlands, the comparative poverty and hard life of the hill country. On the banks of the great Santee we had Hampton, Peachtree, Harietta, Fairfield, and Ormond Hall. Each plantation was a unit unto itself. Each had its school, its church, and its home remedies.

The doctor's understanding of scientific medicine was but little better than the layman's. Bleeding and purging were used by the doctor as a remedy for all types of ills. The medical profession was in disrepute, as is attested by the autobiography of James Marion Sims, a member of the second class in this school

*Commencement Address, Medical College of the State of South Carolina, June 15, 1945.

under its present title. Sims records that when he announced to his father his decision to study medicine, the discouraging reply was: "My son, I confess that I am disappointed in you, and if I had known this I certainly should not have sent you to college. . . . I suppose that I can not control you; but it is a profession for which I have the utmost contempt. There is no science in it. There is no honor to be achieved in it; no reputation to be made, and to think that *my* son should be going around from house to house through this country, with a box of pills in one hand and a squirt in the other, to ameliorate human suffering, is a thought I never supposed I should have to contemplate." The public had lost faith in practitioners of medicine. Cults sprang up. Homeopaths, hydropaths, chronothermalists, thomsonians, mesmerists, herbalists, clairvoyants, and spiritualists were more highly respected and more frequently employed than doctors of medicine. Between 1830 and 1890 eight-five different health magazines published by cultists appeared. The medical profession was especially subject to attack by the clergy, who alleged that disease was the result of sin and that religion would cure all ills, if the doctor didn't interfere. The South Carolina Medical Society in 1850 drew up resolutions condemning the clergy for their interference with medical practice.

One hundred and twenty-two years ago life in South Carolina was rural. The diseases encountered were those of the soil and air, gastro-intestinal, insect-borne, and respiratory. Diseases peculiar to childhood were a problem. Diseases peculiar to aging were not a problem, because few people lived beyond middle life. In 1823 the average span of life in the United States was about thirty-years; today it is about sixty-five years. Hospitals were not available 122 years ago. The practice of medicine was unavoidably "home practice," and was a private affair between doctor and patient.

In 1860 the Civil War changed life in the United States. Industries were developed to provide the implements of war. Transportation improved, and the population played "upset the fruit basket." The armies had to have medical care, so a type of medical practice designed to care for people in large groups made its appearance. Medical problems created by large groups of people living together had to be met. A very vivid picture of the first use of "nurses aides" in war time is found in Margaret Mitchell's *Gone with the Wind*.

War creates changing trends in social and economic life, many of which continue after the war has passed. Revolutionary changes that took place in America between 1865 and 1918 had their roots in the necessities created by the Civil War. The net value of manufactured products showed a steady rise and the net value of farm products a comparable

decline. In 1890, the net value of manufactured products became the greater. In 1920, the total number of people employed in industry became greater than the total number employed in agriculture, and this majority has continued to increase since that time. People make their homes in the communities where they work. Population in the United States has shown a gradual shift from rural to urban areas. The population of the United States in 1840 was 89.2 per cent rural; in 1940 it was only 43.5 per cent rural.

The trend from farm to factory, from handicraft to mass production, from country to city, created new medical problems. Diseases peculiar to industry increased as diseases peculiar to farm life decreased. Medical care for a person working on an assembly line or operating a tractor presents problems different from those of caring for the basket weaver or the person who works with a pick or plow. The shift of population into thousands of small mill or factory communities brought into being the company doctor, whose practice is on a contract basis rather than a fee-per-call basis.

The two World Wars created further social and economic problems influencing medical practice. The changes that took place on a national basis in 1865 took place on a world-wide basis in 1918 and in 1942. The development in transportation has mixed populations and their indigenous diseases to such an extent that doctors practicing in the most remote areas of the United States must have the equipment and knowledge to combat the diseases of the entire world. Fortunately, the development of motion pictures, automobiles, telephones, radios, refrigerators, and airplanes, along with thousands of other useful inventions which have changed living conditions, has been paralleled by advances in medical knowledge which have produced new technical procedures and new instruments of precision.

New inventions make necessary the development of a group of specially trained persons who know how to handle them. The making of modern motion pictures called for people trained in acting, script-writing, directing, lighting, make-up, sound production, and photography. The airplane developed the pilot, the meteorologist, the navigator, and now the flight surgeon, who has special knowledge of the medical problems created by speed and changes in atmospheric pressure. One hundred and twenty-two years ago the mental and physical capacities of a single individual were sufficient to encompass all medical knowledge and to learn the application of all the equipment available for treating human ills. Then, in 1851, somebody invented an instrument called an ophthalmoscope that enabled a person to view the inner structure of the human eye. Dr. Elkanah Williams of Cincinnati became so expert in the use of the instrument and his knowledge of the eye was so superior that in 1855 he began to limit his practice to ophthalmology. In 1895, Wilhelm Konrad von Roentgen discovered the X-ray. The discovery be-

came valuable in medical practice because men with special interest in it and with superior aptitude in physics as applied to human ills devoted their entire intellect to the development of the science of radiology.

Today the American Medical Association recognizes thirty different ethical medical specialties. Others are in the process of development. Yesterday's scientific innovations are today's necessities in the care of the sick. The vast knowledge and skill which make up the science of medicine can no longer be mastered by a single individual. Neither can the equipment used in the diagnosis and treatment of disease be taken to the patient's home. Hence, in order to render efficient service, each physician must have access to a hospital medical center that provides the newer facilities.

We must not assume that the development of medical centers staffed by groups of specialists eliminates the general practitioner. Even though he needs the support of modern science, the general practitioner, like the foot soldier in battle, will always be essential, and will be able, without assistance, to care for the majority of patients who come to him. A tabulation of one thousand consecutive cases seen by five different Winston-Salem doctors which was reported in 1940 revealed that 84-8 per cent had been taken care of with the equipment in the doctor's handbag.*

I hope that I have in a measure succeeded in suggesting to you conclusions that seem obvious to me. The symptoms and signs make the diagnosis plain. We are in a technological age. Human needs are provided for through the joint efforts of people with specialized training. The "butcher, the baker, and the candlestick maker" have become the meat packing houses, the bakeries, and the hydroelectric plants. Good medical care requires the combined efforts of the general practitioner, the internist, the surgeon, the bacteriologist, the chemist, the sanitarian, and the statistician. If all these work separately, medical care can not be other than incomplete. If they work together, the miracles of yesterday become common results today.

Dr. Victor Johnson said in the Founders' Day address at this school on November 2, 1944: "The close interdependence of medical education, medical care, and medical research is asserted much more frequently than it is understood. Medical education has no meaning except as it conceives and meets problems of medical care, not simply in the control of illness in a given patient, but in fostering an understanding of health as a public asset, and of disease as a foe to be met not only in the patient but in research in the clinic and in the laboratory."

The leadership necessary for sound medical care

*"The General Practitioner and His Handbag," North Carolina Medical Journal, June, 1940.

will be furnished in the degree to which medical education meets the responsibility. I suggested earlier in this talk that institutions should be judged by their service to the public. We teach best by precept and example. An agricultural college that grows the finest crops will graduate the best farmers. Progressive medical schools can teach only by providing the best that is known in medical care. The medical student who gains his experience under an obsolete program of medical care will be proportionately limited in his ability to practice medicine in the modern way. Hence, the medical school must train its students in a well planned, well coordinated medical center. It gives me great pride to know that your own school has well developed plans for such a medical center. I congratulate you. Your progress in the past proves that the founders of the school had great vision one hundred and twenty-two years ago. Your vision for the future proves that you are worthy of your heritage.

I know that graduates of today are asking, "What about 'socialized medicine'?" I would ask in return, "What are we talking about when we say 'socialized medicine'?" A service that puts human welfare above everything else is for the good of society; therefore it is "socialized." The motivating force in the life of all true physicians is the desire to help their fellow human beings. Medicine therefore is unavoidably socialized. Organizations interested in social welfare, such as the church, have long shown their interest in the care of the sick through the establishment of hospitals and clinics. Wealthy individuals like Carnegie and Rockefeller have contributed to social welfare by providing funds for medical schools, hospitals, and medical research. As economic trends have reduced the financial ability of individuals, including the doctor, to provide medical care for those unable to pay the cost, city, county, state and federal governments have found it necessary to furnish funds and facilities in increased amounts in order that all the people may get adequate medical care. In a democracy the program of the government is determined by the will of the people. The people of the United States have become conscious to their social responsibility and have become interested in medical care. So-called "socialized medicine" is not a scheme devised by some master mind. It is a natural result of economic and social trends.

This is an age of the greatest medical progress ever known. The medical school graduate of today enters the scene at a most challenging time. You are of good fortune.

In keeping with the duty tradition has imposed on me today, I must give you a final word of advice. The greatest physician of all times said approximately two thousand years ago that man does not live by bread alone. You can not fulfill life's highest ideals through interest in science alone. Keep your life nurtured through close communion with God. By so doing you will multiply your usefulness to others a thousand-fold and will make your own happiness complete.

Surgical Problems in the Returning Veteran*

CAPT. E. B. KECK, (M.C.) U.S.N.R.

The aftermath of war is not only taxes but a conglomeration of complaints by the Veterans. To me, and to some of you I hope, the most interesting will be the surgical problems. The medical problems composed of mental conditions, diarrhea, tuberculosis, and malaria, to mention only a few, are problems which the medical man will meet repeatedly. The surgical problems which we will see most frequently are comparatively few — foreign bodies, amputations, fractures, bowel conditions, liver and splenic disorders, rectal problems, and the skin lesions.

At the head of this list I place the foreign body. I have never been able to understand the patient's reaction to the fact that he was carrying a piece of lead or metal in his body which had been thrown at him by an enemy. In the care of these wounds in the field and in the immediate rear hospitals—no real attempt was made to remove all the foreign bodies. The larger pieces were removed and a reasonable search was made for all others, but due to time, limited operating facilities, and poor condition of the patient, an extended search was not made for all of these pieces and I think you will find that these will lie dormant in some individuals the rest of their lives. In others there will be a constant series of complaints, depending perhaps to some extent on the location and to some extent upon the nervous make-up of the individual. I firmly believe that many men reserve the right to complain about their foreign bodies or their scar tracks whenever it will gain them some advantage. This is not said disparagingly but I am only trying to explain the service man's reaction. We are seeing that now in the case of veterans who have been wounded in action who have spent six to eight months in this country and who are again placed on the overseas list. In the interim since their return home and their orders to return overseas their complaints have been negligible. But upon receiving orders many of them come in complaining of severe pain in the area of their scar or their foreign body. So the first thing to do when a veteran comes to you complaining of pain at the site of his scar track or foreign body must be an evaluation of symptoms, the location, whether he has actual pain, whether he is using this complaint as a possible gain or change from an undesirable job or existence. This may be difficult to determine. There is no way of knowing or proving that he does not have pain and I feel that they should all have the benefit of the doubt, and I always assume that his complaints are genuine. It is true that some of these may be from worry. We have had recently several marines with foreign bodies in the lung—their complaints were not justified by the physical and X-ray findings. Pellets

The Author:

Formerly of Madison, Wisconsin, where he was a surgeon. Dr. Keck volunteered for service and was attached to the First Marine Division. He saw active service overseas at Guadalcanal and Cape Gloucester. At present he is in charge of surgery at the Naval Hospital at Parris Island.

are small and were freely movable with the lung tissue. In these particular cases they would be better off if the patient did not know he had this condition because we do not feel that their removal is indicated. Yet these men have been complaining rather bitterly that they do have pain and it bothers their breathing. There is another instance when it may be true that they have pain but it must come from the scar track of the pleura or intercostal nerve rather than from the fact that the foreign body is in the lung perichema.

I believe another factor to be considered is that the complaints will increase, depending upon local irritation, increase foreign body reaction, and possible movement. As an example I wish to cite one case which I have seen recently, of a man who had spent two and a half years overseas with the First Marine Division and had been through the campaigns of Guadalcanal, Cape Gloucester, and Peleliu. He came into the hospital recently complaining of pain in his knee. He gave a history of having been interrupted in his pursuit of a neighbors watermelons some eight years ago and had received some sixty buck shot in his back, buttocks, and legs. He said he had had no complaints until the present time but was suffering rather severe pain and had been for several weeks. Upon questioning, the point was brought out that he was on an overseas draft to go out again and I think that I was slightly of the opinion that he was using this as a means of escaping further combat duty, although he had had enough. Following X-ray he was found to have roughly the number of buck-shot which he had mentioned but the amazing thing was that in the condyle of the femur there had evidently been four buckshot in the cartilage. Within the past eight years these had been moving, now two of them were in the joint space, one was almost in the joint space, and the other had probably moved toward the capsule cavity. This was a long time following his previous injury but I believe it is what is going to happen with many of the foreign bodies being received today. It is obvious that this man did have pain and rightly so.

We have accepted a plan whereby if a man comes in complaining of pain, and a foreign body is found upon X-ray, and it will not be injurious to his health, we have been removing it. We are particularly

*This paper was read before the First Medical District Society at Walterboro, June 21, 1945.

fortunate in having a Berman locator which cuts down the trauma considerably and cuts down the time element as well. Previous to this we had been locating foreign bodies by means of fluoroscopy but even then the trauma and time were far greater than is necessary with the locator. I have no financial interest in this company but I think one in each community would be a very good investment. I have watched with interest the patients in whom we have removed the foreign bodies and it is true that in a very large percentage their complaints have ceased. There is however one type of foreign bodies which we have not as yet been able to do much for and it is true that the complaints are not very great among this class, and that is the multiple minute particles which are found as a result of fragmentation wounds, leaving hundreds of foreign bodies over a wide area. It is impossible to remove these but as I say the boys do not complain of them except for a burning sensation.

The type of amputation that will be seen by the private practitioner will probably be painful stumps, improper amputations of fingers, toes, and feet. I believe that with the rather extensive Army, Navy plan, that every patient with an amputation of a leg or arm will have been taken care of and fitted with a proper prosthesis before he is surveyed out of the service; and the present plan is that he will have access to the nearest amputation center for years to come to be sure that he maintains the proper fitting prosthesis on a properly healed stump. If his home is too far away from one of these centers, follow up work will be done by the Veterans' Administration, an organization which will probably be rearranged in that there will be ready facilities for this kind of work and an increase in competent personnel. The painful stumps from all statistical reports that I have had access to seem to bear out a fact that they are comparatively few.

Apparent causes of pain in amputation stump neuromas are (1) Scar formation about the regenerating fibers with impairment of circulation. (2) Infiltration of the nerve trunk proximal to its severed end with a scar and; (3) Occasional infection in the nerve trunk. Oddly enough two hospitals which handled the majority of the amputation cases for the Navy and Marine Corps state that the most common site of the painful stump has been the amputated finger, and the treatment of the commonly found medial and lateral neuromas has been one of incision, usually performed by the plastic surgeon. to quote one of these hospitals, they state: "It is apparent that the minimal number of painful stumps which are seen in this hospital is in direct relationship to the technique employed in handling the nerve trunks at the time of the initial or secondary operation. It seems very well established that the following steps are advantageous in lessening painful neuromas: (1) Only slight traction on the nerve trunk during the operation; (2) Severance of the trunk as high as

is practicable with little traction with a sharp scalpel; (3) No injections of the trunk with alcohol or other chemical agents; and (4) Covering the end of the nerve trunk with muscle whenever possible without appreciably altering the course of the nerve. Excision of the neuroma has been the first step in treatment of the painful stump. Burying the severed nerve in bone is a technique advised by Boldey and has continued to give satisfactory results in the hands of his colleagues. Some cases were operated by dividing the involved nerve trunk, proximal to the neuroma and covering the proximal end of the nerve with a tentulum cup holding the latter in place with two or three fine tentulum wire sutures passed through the sheath. The purpose of this procedure has been (1) to minimize the amount of scar formation in the end of the nerve; (2) to prevent scar from adjacent tissues from invading the nerve; and (3) to protect the future bulbous end of the nerve from the irritation of external stimulæ. The cup is rigid and is large enough to prevent constriction of blood supply in the nerve. To date the results of this method with a few cases have been encouraging." In the future I believe we as private practitioners will see only the improperly amputated fingers and toes. We have been seeing a good many of these of late where a poor stump was left on hands and feet. This can easily be explained by the importance that the surgeon places on the smashed finger or toe at time of original injury. Perhaps that is the least of many wounds that the service man has and the surgeon chops of the finger at the easiest possible place and it heals well and by the time the man gets out of the hospital the finger has been pretty well forgotten. Months or perhaps years later the patient finds that the finger is in the way or that it is painful, or interferes with his work and that is the time that he will come to us for advise and help.

The type that seems to need help the most are the men with one of either the third or fourth finger missing at or near the first phalangeal joint, this stump seems to give not only a great deal of pain but also a good bit of annoyance to the good function of the hand and they are always fretting about the appearance of it. We have been getting good results with a reamputation, well back of the head of the metacarpel bone. If this is carefully done with a beveling on both sides of the stump of bone, the cosmetic results are excellent and with the healing the fingers are drawn together and the patient has a much more compact and usable hand. This same procedure has been carried out in the cases of the stiff or poorly amputated little finger or where both the fourth and fifth fingers have been amputated and the stumps are painful or in the way, but cutting and beveling the metacarpel bones at different levels, the hand loses its amputated appearance and although only with the thumb and two fingers remaining the hand is useful and there are no tender prominences.

The same procedures are carried out on the toes.

We have recently had such an example where the patient had had two previous amputations on the little toe of one foot and it was still very tender because the head of the metatarsal had not been removed, he was most uninterested in having a third operation performed, finally he said that anything was better than the pain and fortunately we were able to give him a very satisfactory foot. These may seem like minor surgery but they are very important to the patient and do much towards making him uncomfortable. I am still of the opinion that we are going to see very little of the big amputations in our private practice, these people are going to be taken care of by the government. One other orthopedic procedure that will be noted as time goes by is the increasing need of well done arthrodiases.

We are going to see many painful fractures, for which we will be unable to give the patient any relief. We are also going to see a great many gunshot wounds of the joints. Many of these will be completely ankylosed, and painless. Patients suffering only from the acquired deformity. But we are also going to see many gunshot wounds in joints where there is still some motion and where severe pain exists. This will be particularly true of the bones of the feet, ankles, knees, and elbows. I believe that we can gain much time and the deep gratitude of our patients if we contemplate arthrodesis in these painful joints. In our experience, a man with painful elbows, would much prefer to have a stiff elbow at an angle of about 110 degrees which will enable him to put his hand in his pocket, to comb his hair, to life his hat, and do a large percentage of useful things than to have an elbow with 30 degree painful motion. Pain is a condition which man never gets accustomed to, but a deformity he and his family soon forget if he is happy. This is also particularly true of the bones of the feet and ankle where rather than a painful movable foot, a double or a triple arthrodesis will give a somewhat clumsy foot to appearances but will give relief of pain to the patient.

Painful scars of the skin are problems with not too much hopes to be held out to the patient. The ones in the chest where wounds of entrance have perforated the pleura and leave the commonly seen puckered inverted scar undoubtedly do give the patient pain or at least annoyance. We have resected a few of these scars and performed a full thickness skin graft to cover them. The complete relief of symptoms was present in a very small percentage. Another area of the body in which painful scars are repeatedly complained of are those in the buttocks. These we have also resected and skin grafted and although the portion of relief is higher than in the chest wounds the percentage is not high enough to warrant continuance of the procedure. I do not know what to advise in these cases of painful scars. Deep X-ray has been suggested and used with only so-so results. I think perhaps that time, mild massage,

and diathermy is the treatment of choice.

I am anticipating considerable complaint by the men who were wounded through the abdomen, and I feel out of all the wounded of this war these men have the most reasonable claim for complaint and strangely enough, since I have returned to the States I have seen fewer of these patients than of any other type of war injury. It was my privilege to do a considerable amount of surgery with the First Marine Division from early 1942 to 1944 — a method of surgery that could hardly be recommended for a Grade 1 hospital in the United States — and I was always somewhat amazed that so many wounded lived and seemingly got along very well. It was not uncommon to find anywhere from three to twenty perforations in the bowel as a result of mortar, hand grenade, or other implements of war. And where time was an important element as it always was. We always attempted to close the perforations with a transfer stitch rather than resect and I know on many occasions I decreased the lumen of the bowel to a degree which would almost seem obstructing. But one's argument in favor of the procedure was that when this patient came to a rear base a resection could be done at that time. Amazingly very few of these patients have come to secondary surgery. It seems that a good meal will make the lumen normal in size. I have had the opportunity to have studies done on such patients, a year, two years, since the original operation and find no X-ray evidence apparent that a repair of the bowel had been performed. Perhaps what you can not see will give you no trouble. This applies to the small bowel pathology—this is not true of upper abdominal and large bowel trauma. I think we may be sure that the man who is shot through the liver, stomach, spleen, or transverse colon will be a persistent patient.

This is due no doubt to the nerve and blood supply of the upper abdomen and as we all know the patients stand upper abdominal surgery much more poorly than in the lower abdomen. What can we do for these people? Surgically, I believe—nothing. The treatment is psychoanalytical or the calm reassurance of the family doctor.

We owe the exserviceman a great deal, and one of the least is considerate and conscientious medical and surgical care. One thing that we must remember, especially those who may practice in the northern states. You who live here in the malarial area no doubt have already discovered the fact. Surgery superimposed upon latent malaria will invariably cause an exacerbation of the disease. It seems that for several years to come any chill and fever must cause us to think at once of malaria.

It is true that many of the exservicemen will be treated by the Veterans Administration but no matter what they have to offer, the patients will wish to return to their family practitioners for their final care.

Proportion of Male to Female Live Births During Wartime

GEORGE D. JOHNSON, SPARTANBURG, S. C.

For a long time, there has been an impression among lay as well as medical circles that during wartime the ratio of male to female births becomes greater. In an attempt to determine the truth the following figures have been collected from Roper, Greenville General and Spartanburg General Hospitals.*

Very little information on the actual reasons for a change in the ratio of male to female births could be found. 1. As far back as 1742, Suessmilch, a priest in the army of Frederick II stated that it was the intercession of Divine Providence to compensate for the large number of males slaughtered in wartime. Another explanation is that with the removal of a large proportion of the male population there is a longer interval between pregnancies and the maternal organism is thus in better condition to support the male fetus which normally suffers a greater mortality than the female. Another theory is that malnutrition and famine favor the development of a male fetus.

During the last war in Germany, Austria, and Australia there was an increase of males over females from the normal of about 106 males to 100 female live births to 108 males to 100 females.¹ Such an increase did not occur in the United States. The reason commonly given is the large percentage of the population in the armed services. In Germany and Austria fifteen to twenty percent of the population was in the armed services while in the United States at most four per cent was in at one time. These figures decreased rapidly a few years after the war.

Two explanations for the increase in war time have been offered. First, as a result of a large number of

* (Without the help of the medical record librarians in these institutions this article could not have been written. Sincere appreciation is hereby acknowledged.)

The Author:

Dr. Johnson is a practicing pediatrician in Spartanburg and is a Licentiate of the American Board of Pediatrics.

marriages contracted in war time, there are more first born children and among first born children the number of males is greater than the number of females. The second reason is the decrease of miscarriages after wars because of the desire to have more children.¹ This means a higher male rate among live births, because in miscarriages and still births there is a larger number of males than females.

In this study figures were obtained from three of the large institutions in the state. Births during 1941 and 1943 were used to represent before and during the war respectively. Large figures were not obtained but it is felt that they represent fairly the ratio of births over the state.

	1941	
Females		Males
1204		1233
	or	
100 1/3		102 3/4
	1943	
Females		Males
1782		1795
	or	
104		105

From these figures it seems safe to say that there is not an increase in the ratio of male to female live births during wartime where no larger a percentage of the population is involved than is in this country.

¹ Medical Record, 115:117 (Feb. 18, 1942.)

Intrathoracic Goiter

F. T. WALLACE, M.D., SPARTANBURG, S. C.

An intrathoracic goiter usually has its origin in the lower pole of the thyroid gland. The extension may be from a discrete adenoma or a multiple colloid adenomatous (nodular) goiter. Carcinoma of the thyroid may extend into the mediastinum, but need not be considered from the standpoint of operative removal at this stage. Primary intrathoracic goiter, probably arising from an epithelial rest, has been reported but is so exceedingly rare that it will not be discussed here.

The attachments of the pretracheal muscles predispose to extension of a lower pole adenoma into the thorax. Growth anteriorly or superiorly is limited by these muscles and their attachments to the sternum, larynx, and hyoid bone. Extension occurs downward through the superior strait of the thoracic cage into the mediastinum.

There are two main effects of an intrathoracic goiter. One is that the mass displaces and compresses the trachea and a progressive respiratory obstruction develops. The second major effect is an interference with the venous return. Venous pressure rises and the veins of the head, neck, and upper thorax become tremendously distended. Considerable interference with the cerebral circulation may result. In the advanced stages, a putty-like edema of the face occurs.

The possibility of an intrathoracic extension from any goiter must be kept in mind in the preliminary examination of the patient. Extension into the mediastinum may be suspected when thyroid tissue continues inferiorly below the examining finger when the patient swallows. The mediastinal mass is discernable on an X-ray of the chest, particularly if centered over the upper mediastinum. A lateral X-ray gives additional information in many cases. It is wise to secure a preoperative X-ray of the chest on all patients that are to have a thyroidectomy; otherwise a mediastinal extension may be overlooked.

The ideal treatment is prophylactic. Intrathoracic extension should be prevented by early removal of lower pole adenomata and nodular goiters.

In the early days of surgical treatment of intrathoracic goiter, division of part of the anterior thoracic cage was frequently performed. Mediastinotomy is now only rarely necessary. Lahey¹ has emphasized the technique for removal of an intrathoracic goiter whose transverse diameter is considerably greater than the superior strait through which it must be delivered. The usual transverse neck incision for thyroidectomy is used. The pretracheal muscles are divided transversely (well above the level of the

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The Author:

This paper was prepared while Dr. Wallace was a member of the Department of Surgery, Medical College of the State of S. C. Dr. Wallace has recently opened his offices in Spartanburg.

skin incision to prevent a deeply adherent scar) and reflected. The attachments of the thyroid in the neck are divided and ligated, particularly the upper pole, the lateral thyroid veins, and the tracheal attachments. The inferior thyroid artery cannot usually be secured until the intrathoracic portion has been delivered. If the mass cannot be manipulated through the superior strait, the capsule is incised and the inner portion of the mass is broken up with the finger and removed. This can usually be accomplished without much bleeding, since most of the blood supply has already been secured in the neck. The diameter of the mass may be decreased by this process of morcellation so that delivery of the mass is possible.

Prioleau² has modified this technique, particularly in regards to the maintenance of an airway. Rather than use the customary general anesthesia administered through a rigid intratracheal tube introduced after the patient is asleep, he accomplishes the first part of the procedure under local anesthesia. The trachea is exposed and prepared for a tracheotomy as the first step. If too much tracheal compression occurs during delivery of the intrathoracic mass, a tracheotomy tube can be quickly inserted. General anesthesia can be given through the tracheotomy tube if it should be necessary. His technique avoids a dangerous induction of general anesthesia in a patient with considerable compression of the trachea.

CASE REPORT

Roper Hospital No. 24809. A 62 year old colored female was admitted to Roper Hospital September 29, 1944. The patient had been aware of a mass in her neck for 15 years. One year prior to admission while walking to work the patient had a sudden episode of "choking" which rendered her unconscious. Spontaneous recovery from this attack occurred in a few minutes. Since that time, the patient has had a feeling of constriction in her chest, accompanied on occasions by difficulty in breathing. She noted a progressive difficulty in swallowing solid foods. One week prior to admission, she had another episode of unconsciousness preceded by a choking sensation.

A review of previous records revealed that there was an admission in January, 1944, at which time the patient had lobar pneumonia. A large adenoma of the thyroid was noted and a mediastinal mass was seen on radiological examination. Removal was ad-

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EDITOR: Julian P. Price

Florence, S. C.

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A PRAYER FOR AMERICA

The night of war has passed, the day of peace has come — for this, O God, we give Thee thanks. In Thy might and in Thy goodness, Thou hast given us the victory — for this we raise our hearts in gratitude. Thou has bestowed upon us a position of power amongst the nations of the earth and hast entrusted to our care the leadership of mankind — give us wisdom and give us humility in this great task. Cast out all greed and hate from our hearts, grant us guidance and fill us with Thy love as we plan for the morrow. Lead us that we may build a new world upon the foundations of the Rock of Ages.

Amen.

The 195 meeting of the House of Delegates will be held in Columbia, October 2, at two p. m., at the Columbia Hotel. A decision to have this meeting was made by Council at a special meeting on August 30.

Several matters of extreme importance will be considered and there will be the usual election of officers, councilors, et cetera.

All delegates are asked to bring their credentials and to check them with the credentials committee which will convene at 1:30.

Council will hold a short session at noon and any matters for consideration by Council should be submitted to its Chairman, Dr. Frank G. Cain, before that time.

FEDERAL MEDICINE

(Editorial Musings)

In the July issue, we made certain observations as to the attitude which might be adopted by physicians toward the Wagner-Murray-Dingell Bill. We mentioned various arguments which have been advanced against the bill, some of which we did not believe sound and which we suggested should be discarded.

As a complement to that line of thought, we wish to present three reasons which we have for opposing this bill or any legislation which calls for governmental control and administration of medical care.

1. "As a taxpayer, I am opposed to a federal system of medical care because it is too costly and because it is unnecessary."

Various estimates have been made as to the cost to the taxpayers (for they are the ones who ultimately pay the bill) of administration and operation of a federal system of medical care. The estimates run from two and a half billion to six billion or more a year. Let us assume that the cost would be a minimum of three billion dollars annually — and that is a conservative figure.

We have become so accustomed to vast expenditures for war purposes and money has been so plentiful in recent years that three billion dollars appears to be a relatively small sum. But the day of reckoning must come. The national debt must be gradually reduced, the annual interest on the national debt (which amounts to over four billion dollars a year) must be paid, vast sums will be required to care for our disabled veterans, a public works program appears in the offing — these are but some of the expenses which this country faces in the post-war era in addition to the tremendous administrative cost of federal, state, and local governments as they now exist. To add three billion dollars a year to this burden which the taxpayer is already carrying is poor financial judgment in our opinion.

Furthermore, we do not believe that such a program for medical care is necessary since the same results may be obtained through effective and less

expensive methods. If provisions were made whereby anyone who desired could arrange for the prepayment of hospital and medical services — and great progress has already been made in this direction — the result would be as satisfactory as would a compulsory insurance (federal) system. One advantage to the voluntary pre-payment system is that it is built around many different types of plans — each of which can be adapted to local needs. Such would not be true of an all-inclusive single system administered on a national scale. Another advantage of the voluntary system would be that it would cost the participants less. History has proven that enterprises under private management can operate at less expense than can governmental agencies.

It should be noted in passing that no provision is made for the overall care of the indigent sick in any of the proposed federal medical care programs. It would appear that if the intelligence and ingenuity of the individual states and of the various counties and communities over the nation are capable of providing for their indigent sick, they are also sufficient to make plans for those who belong to higher financial level.

2. "As a citizen, I am opposed to a federal system of medical care because it is in direct opposition to the fundamental American principles of personal initiative and personal responsibility."

Our country was founded and was developed by men and women driven by the dynamic urges of self preservation, protection of the family, and self advancement. Individual freedom and responsibility were as much a part of their being as was freedom of speech and freedom of religion. As the nation grew to maturity a sense of social obligation developed — an obligation on the part of the state to care for those who could not care for themselves. But at no time has the American tradition been that of spoon-feeding those who were strong enough to feed themselves.

We are in favor of making available to all the people good medical care at a price which they can afford to pay, and we are willing to cooperate with

those — be they physicians or otherwise — who are working toward this end. But we contend that no one, not even the Federal Government, should be allowed to trample under foot that right of personal initiative and that sense of personal responsibility which are the heritage of every American citizen. We advocate the principle of pre-payment in the field of medical care (through insurance and through hospital and medical service plans), and we urge that every effort be made to make such a method of pre-payment available to all. But we insist that the final decision as to whether to purchase the insurance be left to the individual and not to a paternalistic government in Washington, as would be the case with a federal system of medical care.

During time of war, there had to be a centralizing of power in the federal government with the establishment of bureaus and governing by executive orders. But a bureaucratic form of government is not the American way. As a patriotic citizen we were glad to abide by the rules and regulations laid down by the various agencies which grew out of our national crisis, but we insist that these agencies should be discarded as soon as the national emergency has passed. If this is true of agencies which dealt with material things how much truer is it of a gigantic bureau which would deal with the physical lives of our people. An O. P. A. was necessary in time of war and was in accord with our democratic way of life, but an O. M. A. (Office of Medical Administration) is not necessary in time of peace and is absolutely opposed to our democratic way of life. The town hall and not the governmental bureau has been and must continue to be the strength of America.

3. "As a physician, I am opposed to a federal system of medical care because,

(a) The medical needs of our people could not be served by a single central plan."

As we have talked with individuals from various sections of our country and as we have observed at first hand conditions as they exist in different areas, we are convinced that no single central plan could serve the medical needs of all our people. The Social Security Administration realized this when it first began to function and a large proportion of our people were excluded from its benefits. Even now efforts are being made to change this situation but whether the proposals now under consideration will be workable or effective, only time will tell. How much truer would this be of a gigantic federal bureau of medical care which would be rendering a personal rather than a financial service.

To be effective, we believe that medical needs must be met and dealt with on a local, or at most on a state, level. Certain communities and certain states may need financial assistance from the federal government in providing medical service for their citizens, but we do not believe that they need dictation of policy or regulation of action.

"(b) The experience of other countries has not shown its great worth."

The government which was able to more nearly control the entire medical care program for its people than any other was Nazi Germany. Reports recently received indicate that under Hitler's regime medicine and medical care suffered a decline — and this in Germany with its wonderful record in medical history. England has had a modified form of governmental medical care for many years but we do not believe that medical service for the average citizen in England has been as good as it has been in this country. We have studied reports coming from various countries and we are not convinced that any system of governmental care yet evolved has equalled the care available in this country today. We do not imply that medical care in this country does not need to be improved — there is room for much improvement — but we maintain that the establishment of a federal system of medical care is not the method to obtain that end.

"(c) Such a system is not necessary to bring about the improvements which are needed in our present system of medical care."

We are not blind to the weaknesses which exist in our present day system of medical care. We see clearly the need for more preventive medicine, for better care of expectant mothers and of children, for more hospitals and diagnostic clinics, for adjusting the cost of medical care to the financial abilities of the patient. But we maintain that all of these problems can be met by a judicious expansion of means now at our disposal. We believe that a cooperative effort by leaders in government, in industry, in labor, in agriculture, in public health, and in medicine can bring about the results which we desire. And we stand ready to join in such an effort.

"(d) No physician can serve two masters and do his most effective work."

In its final analysis medical care is a personal relationship and a personal transaction between a patient and a physician. It is not an item which can be sold across the counter or a commodity which can be traded in bulk. A hospital on every corner and a diagnostic clinic at every crossroad would serve no profitable end except as they were used by trained and conscientious physicians in behalf of individual patients.

Medical science is not static, it is progressive and the accepted practice of today may be the obsolete practice of tomorrow. Disease and the need for medical care do not conform to laws laid down by man, they must be appraised in each instance and be dealt with accordingly. Each patient must be an individual problem for the individual physician's study — never a punched card to be fed into a lightening calculator or a form to be filed in a designated folder.

To do his best work, a physician must have as his first obligation the welfare of his patient. The master whom the physician serves in the field of medical practice must be the patient — and such is the case under our present system of medical care.

Under a federal system of medical care the physi-

cian would be confronted with a second master, that of the governmental bureau which operated the plan. It would be an impersonal master composed of rules and regulations, printed forms and red tape, and a federal administrator in an office in Washington.

Little imagination is needed to see the difficulties which would confront the physician as he attempted to serve his two masters — the patient and the governmental agency. The needs of the patient might not conform to the inflexible rules and regulations of the bureau. The physician would be faced with two choices; to place the patient first in his consideration as his training and professional judgment direct and

run the risk of offending the agency, or to follow the regulations as laid down by the agency and allow the patient to take the consequences. A single instance of this type might amount to little but a series of such incidents — and we do not see how this could be avoided — would result in an open clash between the physician and the agency with the agency always holding the whip hand, or else in an inferior medical service being rendered to the patient.

We are opposed to any system of medical care which would force a physician to serve two masters. If he is to do his best work he must serve only one — the patient.

The Ten Point Program

M. L. MEADORS, EXECUTIVE DIRECTOR AND COUNSEL

THE MATERNAL AND CHILD WELFARE ACT OF 1945

A Bill (S. 1318), designated as above, was introduced in the United States Senate on July 26th by Senator Pepper and nine other members of the Senate Committee on Education and Labor. It is divided into three parts, each treated under a separate "title."

The Bill provides for appropriation of a total of \$100,000,000.00 for the fiscal year ending June 30, 1946 and thereafter in each year a sufficient sum to carry out the purposes intended by the Bill.

The services proposed and the amount allotted for each from the total appropriation authorized for the first year are:

Maternal and child health	\$50,000,000.00
Services for crippled children	25,000,000.00
Child welfare services	20,000,000.00

The remaining \$5,000,000.00 is earmarked for the expenses of the Children's Bureau in administering the provisions of the Act and in developing and promoting effective measures for carrying out its purposes, including studies, demonstrations, investigations, research, training of personnel and payment of salaries and expenses.

The general provisions for application of the funds provided for the three different types of services, and the methods of administration prescribed, are almost identical. All activities are placed under the supervision and direction of the Chief of the Children's Bureau within the Department of Labor; all are to be administered through state agencies in accordance with state plans drawn up according to basic principles set out in the Bill, and these plans must be approved by the Chief of the Children's Bureau. Each plan must provide for financial participation to a substantial degree by the state, and for its administration or the supervision of its administration by the State Health Agency as to the first and second types of service, and in the case of the child welfare ser-

ices, by the State Public Welfare Agency. All plans must provide for state-wide programs, and services contemplated must be available to all mothers (where applicable) and children in the state who elect to participate, without discrimination because of race, creed, color or national origin.

The state plans must also provide for efficient operation and include personnel standards on a merit basis and standards for professional personnel established by the State Health Agency or State Public Welfare Agency, after consultation with professional Advisory Committees appointed by such agencies. The methods of administration of medical care under the first two titles must insure the right of mothers and children to select the physician, hospital, clinic or health service agency of their choice from among those meeting the standards prescribed by the State Health Agency, and the state plan must set forth the method by which such care shall be made available where no selection is made. The plans must provide for the rendering of a high quality of medical care and related services, opportunities for postgraduate training of professional and technical personnel, payments to individual physicians on a per capita, salary, per case or per session basis and, in the case of consultations or emergency visits, on a fee-for-service basis. The State Health Agency (and the State Public Welfare Agency where it is concerned) would make reports according to the form, and containing the information prescribed by the Chief of the Children's Bureau. A general Advisory Council would be appointed by the State Health Agency under each of the first two titles, composed of members of the professions or agencies, public or voluntary, that furnish care or services under the state plan, and of other persons representing the public and informed on the need and problems in connection with the services proposed. Where the State Health Agency administers the program of services to crippled children, the same Advisory Council would serve in connection with both that program and the program for ma-

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ternal and child health. An opportunity for a hearing before the State Health Agency would have to be provided for those whose claims for service were denied, and for those physicians or other persons or organizations participating or desiring to participate under the plans for maternal and child-health services and crippled children's services.

The funds would be allotted to the states on the basis of the proportionate number of children under the age of 21 years in each state to the total number of such children in the United States. The funds would be payable upon certification by the Secretary of Labor of the amount estimated by him on the foregoing basis, such estimates to be made not less often than semi-annually and adjustments to be made in subsequent payments in cases where previous estimates proved inadequate or more than sufficient for the actual needs.

The funds so provided by the Federal Government would have to be matched dollar for dollar by the states with respect to each of the services, except that with reference to the child-welfare services in those states whose per capita income is less than the per capita income of the continental United States federal funds would be matched by state or local funds amounting to not less than 25% of the total expended.

In respect to the maternal, child health and crippled children's services, the Chief of the Children's Bureau would be directed to formulate general policies for administration after consultation with a conference of State Health officers and an Advisory Committee composed of professional and public members and, if necessary, technical Advisory Committees to be appointed by the Chief of the Children's Bureau. The state plans relating to the three services would be made part of the state plan for such services submitted in accordance with the provisions of Title 5, Parts 1, 2 and 3, respectively, of the Social Security Act.

The maternal and child health services contemplated include services and facilities to promote the physical and mental health of mothers during the maternity period and of children, and related services and facilities for maternity care, preventive health work and diagnostic services and school health services for children, care of sick children and correction of defects and conditions likely to interfere with their normal growth, development and educational progress. The crippled children's services contemplated are those naturally suggested by a broad interpretation of that term.

Obviously and in brief, the Bill provides, therefore, for a broad expansion and continuation after the war of the EMIC Program now in effect and the services now provided under the crippled children's program administered by the State Boards of Health.

The child welfare services would include programs and measures for providing suitable care and protection for children who are without such parental care and supervision and for those who are depend-

ent, neglected or delinquent or in danger of becoming so.

Finally, the Chief of the Children's Bureau, with the approval of the Secretary of Labor, would be authorized to make and publish rules and regulations necessary to the efficient administration of the Act, and to submit each year to the Congress a full report of its administration.

Senator Pepper, in introducing the Bill, referred to it as "a modest beginning." He pointed out that according to estimates by reliable authorities, medical care and health supervision of children amount to between \$25 and \$40 per year for each child, or a total of at least \$1,000,000,000.00 for the 40,000,000 children under 18 in the United States. He said further, "If we were at peace, the sums called for now would appear inadequate in the extreme. But we are still at war. We can only inch ahead at this time. . . Obviously, a nation-wide child health and child welfare program is not something that can be created in a year. . . The authorizations for appropriations that we are suggesting for this year will give us a fair start toward our objective, though it will be only a beginning."

Since the foregoing statements were made, peace has come. We are no longer at war and the necessity recognized by Senator Pepper for "inching ahead" presumably exists no longer. Conceding even that he might realize the desirability of holding the program to these "modest" proportions for the first year or until some progress toward post-war readjustment is made, it is reasonable to infer from the Senator's statements, that ere long the drive will be on to accelerate the "fair start" toward achievement of the objective — universal service of the types provided, at the expense of the Federal and State governments.

THE NATIONAL SCENE

With the nation's medical bill in 1944 totaling \$4 billions, and a capital investment in hospital plant and equipment of \$6 billions, medicine today is one of the big businesses of America, says the current issue of *THE INDEX*, quarterly publication of The New York Trust Company, in a discussion of socialized medicine. The direct consumers of medical care, it was explained, paid \$3 billions of last year's bill, expenditures by federal, state and local governments were \$800 millions, and the balance was contributed by industry and philanthropy.

Analyzing the relation of national health to output of goods, the bank pointed out that in 1943, the nation's peak production year, approximately two billion dollars worth of purchasing power was lost because of illness. The male industrial worker, the report states, lost an average of 11.4 days during the year largely on account of common ailments, and the female worker lost an average of 13.3 days. The bank challenges the belief held in some quarters that more people can receive more benefits from the science of medicine if the profession is socialized.

More than 60,000 doctors, one-third of the licensed physicians and surgeons of the country, are in the armed services today, says the study. Paying a high tribute to the quality of their training, the bank maintains that their professional competence, plus the aid of new drugs and modern methods, were largely responsible for the fact that 96.1 per cent of the 1,375,000 American wounded in the European theater of operations were saved.

Before the war, it was found, counties with a per capita income of more than \$600 had eight times as great a proportion of physicians to population as did counties with a per capita income of less than \$100. Physicians rank third in earning ability among the independent professions, says the report, following that of the certified public accountant and the lawyer. This relatively high income, it is held, is in the nature of a dividend from a substantial educational investment because most doctors today have spent six years, plus \$15,000 to \$20,000, in preparing themselves for their profession.

"But medical facilities," the study continues, "are as unevenly distributed as medical personnel. Throughout the country there is one general-hospital bed to every 263 of the population; the best statewide ratio is 1 to 196, the most unfavorable, 1 to 667. Forty per cent of our counties, with an aggregate population of more than 15 millions, have no registered hospitals.

"The country's future hospital development will be influenced necessarily by the needs of World War veterans. The Veterans' Administration, with a background of twenty years experience in the supervision of a medical program, was operating hospital facilities in 1942 at 92 locations in forty-five states. With a total investment in buildings of \$213 millions, annual operating costs stood at \$65 millions. Current plans call for the provision of 275,000 to 302,000 beds, as compared with the 101,275 beds presently available or authorized.

"During the next twenty years, the Veterans' Administration contemplates the development of a physical plant which will represent an additional investment of a billion dollars. Present expenditures indicate that the annual operating costs of a hospital plan of such magnitude will approximate \$300 millions annually.

"In cost to the taxpayers, the medical aspects of public welfare are of growing importance. Ten years ago, \$3.2 billions were invested in hospitals, half of which was subscribed by the Government, 45 per cent came from voluntary gifts, and the remainder from commercial sources. Tax funds today supply some \$200 millions annually for hospital care of mental diseases, a similar amount for the care of the indigent in voluntary hospitals, and \$60 millions for home medical care. Practically the entire amount needed for hospital care of tuberculosis and other communicable diseases comes from the Government."

Against the foregoing background of facts and figures, the study looks into the current and probable

future trend toward socialization.

"Two hard facts, widely quoted," it continues, "are sufficient to point up the relation that exists between finances and health: (a) for the ten most important diseases in this country, the death rate is approximately twice as high among poorly-paid unskilled laborers as among well-paid professional people; (b) the life expectancy of workers in industry is eight years less than that of those who are not employed in factories and mills."

"There are many definitions of socialized medicine and its importance appears to depend primarily upon the professional bias, political ambition, emotional inheritance, and economic status of the individual. But the crux of all ideas is federal control to a dominating degree; and the subject is discussed in this sense in the present analysis."

After discussing the activities of the Senate Subcommittee on Wartime Health and Education and the efforts to broaden the Social Security Program through the Wagner-Murray-Dingell Bills and similar proposed legislation, the study compares the probable effect of the trend to that of the principle of economics known as Gresham's Law — "bad money drives out good" — by pointing out that according to the statement of one authority, "We would find that under compulsory health insurance there would exist for a time two types of medical practice: (1) that rendered by private practitioners — a superlatively good but expensive service; (2) a more or less sub-standard type of service rendered by the government system. Eventually the sub-standard would drive out the superior type of medical practice until all medical practice would be reduced to a common denominator lacking in effectiveness, in scientific attainment and dominated by rules and regulations of a medical bureaucracy."

The Index continues with a discussion of the medical prepayment plans, stating that there are several hundred voluntary medical indemnity plans now in operation throughout the country. Membership in hospital plans, it points out, far outstrips that in the plans having surgical coverage, there being about 18,000,000 persons enrolled in the Blue Cross Plan alone. The whole prospect of possibilities in the insurance field is ably discussed, including not only the non-profit types of insurance referred to above but also the activities of regular stock and mutual insurance companies and the effects of the Workmen's Compensation laws.

After an unusually objective and discerning discussion of the whole situation, The Index concludes: "Certain significant facts emerge from the violent controversial discussions surrounding the above questions. Voluntary efforts are presently getting into their real stride. They have not proved to be a drag on the country's high quality of medical proficiency or the brilliant progress made in research. By expanding and improving our public health service, by supporting various group and community systems, and by encouraging private insurance companies to

add to the usefulness of their services, the country should find that federal control of medicine is not necessary to insure a healthy nation. Historically the experience of foreign countries provides no evidence to the contrary."

MEDICAL CARE PROGRAMS

The trend within recent months toward the development of programs for medical care by organized medicine, or with which the latter is connected, has been impressive. Reference was made in this column and elsewhere in the Journal last month to the Constructive Program for Medical Care recently adopted by the Council on Medical Service and Public Relations and the Board of Trustees of the American Medical Association.

The adoption of this Program is perhaps the most significant development and the one most strongly indicative of the realization by the profession as a whole, and particularly by the officials of its organization, that the necessity exists for definite, positive, planned action now and in the future. From this time forth, this constructive program may well provide concrete leadership for the profession on a national scale. Until its adoption, however, the American Medical Association can hardly be credited with the ideas and with the steps heretofore taken by various state and other organizations.

Another program just instituted, and which presents a different and interesting approach to the problem, is that of the Michigan Health Council. This is not an effort solely by the doctors of Michigan, but represents the combination and coordination of their influence and support with that of other organizations of the state which have a common interest. The Council was incorporated a year ago as a joint organization of the Michigan State Medical Society, the Michigan Hospital Association, Michigan Medical Service and Michigan Hospital Service. The general purpose behind the organization is indicated by a statement contained in a booklet recently issued by the Council: "Because undue concentration of authority limits freedom, restricts progress, and may lead to social injustice, proposals for government to become the dominant power in the American system of health care constitute a serious threat to the health welfare of the American people."

The Michigan Council's statement points out that "democracy by its very nature forbids undue centralizing of authority." It urges thoughtful citizens to:

Examine every new plea for governmental aid, every proposal to delegate further authority to government.

Resist each such demand until it has been proven beyond question that the ultimate common good can best be served in no other way.

The booklet is published under the title "Better Health for the American People." It undertakes an analysis of the reasons why a democratic system of health care offers greater promise than any other system.

Five objectives for the attainment of better health care by democratic means are set forth in the booklet. They are:

1. Complete Health Pre-Payment Service for the Self Supporting.
2. Cooperation with Government to Furnish Health Care for Those Unable to Pay.
3. Improvement of Health Facilities and Standards.
4. Health Education of the Public.
5. National Coordination of Health Activities.

The Charlotte Observer of August 11th carried an article announcing the beginning of its work and the program to be followed by the North Carolina State Medical Care Commission. This Commission, according to the Observer, "has been intrusted with the opportunity to work out one of the greatest and most far-reaching social programs in the history of the state." At its meeting in April, the Missouri State Medical Association adopted a four-point program to provide more medical doctors, hospitals and clinics for rural Missouri. Apparently one of the principal objectives was to encourage a more even distribution of medical care by offering educational assistance and other inducements to young physicians who would agree to locate in the rural areas.

These are only a few. A number of other and similar programs newly begun throughout the nation might be referred to. Nor is the movement confined to the United States. We were interested in the account contained in the June issue of the Ontario Medical Review of the steps being taken by the medical organization of that province to align the profession with forward looking movements in connection with medical care in Canada. According to the Review, a plan has been drafted by the Canadian Medical Association with respect to national health insurance, and the delegates from the Ontario Association were instructed to make recommendations accordingly at the meeting of the Canadian Association in June. It is pointed out that the recommendation "concerned the giving of leadership by the medical profession so that, if and when, the people of Canada vote for national health insurance there will be available the views of the profession to act as a guide." It was pointed out definitely that the Association was not urging the adoption of national health insurance, however. The article continues by stating that there is little evidence for support of compulsory health insurance at the present time although it seems clear that the public is becoming increasingly desirous "of covering the major cost of illness through small regular payments."

The crux of the Canadian thought and present line of action was expressed in the following sentence contained in the article referred to: "They felt that leadership should be given by organized medicine through a voluntary plan inaugurated at the earliest possible moment." Further action was taken toward the adoption of a plan for surgical and/or complete medical services to be operated by the Ontario Medical Association.

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DIFFERENCES

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**Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

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TEN POINT PROGRAM
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SOUTH CAROLINA MEDICAL ASSOCIATION

1. Cooperation

To promote closer cooperation and better understanding between all groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Political Control

To prevent political control or domination of medical practice or of medical education.

3. Study

To assemble and to amplify studies relative to the need and availability of medical care in each county of the state and in the state at large, and to publicize these findings.

To study all agencies in the state which are involved in the administration of medical care as to the type of work which they are doing and the effectiveness of the work which is being done.

To promote plans for providing or improving medical care where there is a need.

4. Care of Indigent

To prepare a uniform plan for the hospital care of the indigent, financed by public county funds, which may be used by individual counties or by groups of counties for their indigent sick, and to promote the general adoption of such a plan.

To promote the establishments of clinics in each county for the indigent ambulatory patients, financed by public county funds and operated or supervised by established hospitals or by the county medical society.

5. Hospital Insurance

To make voluntary hospital insurance available to all the people of the state and to promote the widespread purchase of such insurance.

6. Hospitals

To study the present availability and facilities of hospitals in the state and to promote the establishment of well-equipped and adequately-staffed hospitals in needy areas.

To establish through the State Medical Association standards for hospitals in South Carolina and to make public the names of those hospitals which meet these standards.

7. Group Health Insurance

To promote the establishment of group health insurance plans in all industries, large and small, in South Carolina.

8. Standards for Insurance

To establish standards for insurance companies selling hospital or group health insurance in South Carolina and to publish the names of those who meet these standards.

9. Medical and Nursing Education

To promote the securing of adequate funds and facilities for the operation of the Medical College of the State of South Carolina.

To promote advancement in nursing education and nursing care in the state.

To promote the establishment of a loan fund whereby worthy young men and women of the state who are financially unable to meet the strain of a medical education may be able to secure aid.

10. Education of the Public

To acquaint the citizens of the state with regard to the agencies and facilities in the fields of medical care, public health, hospital and industrial insurance, and to encourage the people to use them on a much greater scale.



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PUBLIC HEALTH NEWS

FOUR IMPORTANT RESOLUTIONS ADOPTED BY EXECUTIVE COMMITTEE

Dr. Lynch Paid Special Tribute For 10-Year Service

At the June 20 meeting of the Executive Committee of the State Board of Health the following resolutions were adopted:

1. That a request be made of the President of the South Carolina Medical Association and the President of the South Carolina Pharmaceutical Association to appoint two members of their respective Associations, preferably from Columbia, to serve as a committee with the South Carolina State Health Officer.

This Committee will serve as an Advisory Committee to the Medical profession and Pharmaceutical profession, through reports in each profession's monthly publication, when necessary, on matters pertaining to the sale, use, and distribution of all drugs, pharmaceuticals, biologicals, serums, and vaccines, particularly those which will in any way effect each profession from an ethical standpoint or that are questionable and interfere with pending restrictive legislation.

This Committee will also serve in an advisory capacity to the Executive Committee of the South Carolina State Board of Health on matters pertaining to the distribution of drugs and biologicals.

Term of Office on this Committee shall be for one year. Upon expiration of any member's term he may be re-appointed or his successor named.

2. That Dr. Ben F. Wyman, State Health Officer, apply to the Budget Commission for a transfer of

funds not to exceed \$5,000 from the \$40,000 budgeted for maintenance and operation of the South Carolina Convalescent Home, located at Florence, for the purpose of providing proper fire protection, especially a more adequate water supply.

3. That the present maximum of \$50.00 for therapeutic X-ray and Radium treatment on State-Aid Cancer patients be increased to \$60.00 for the fiscal year 1946. And that the present rates on the various dosages of therapeutic X-ray be continued but that no differentials be made as to maximum amounts allowed for X-ray or Radium.

Heretofore the maximum allowance for X-ray treatment of the skin was \$25.00; for deep therapy, \$35.00, with an additional \$15.00 if Radium was used. As amended, the maximum allowance would be \$60.00 without regard to the kind of therapy used, provided it is calculated on the basis of the existing rates for X-ray and Radium therapy.

4. WHEREAS, From April 23, 1935, through May 16, 1945, Dr. Kenneth M. Lynch has been a member of the Executive Committee of the State Board of Health of South Carolina continuously, and since May 1, 1940, he has served as Chairman of said Executive Committee; and

WHEREAS, Dr. Lynch has served faithfully and has made many sacrifices, and contributions of time and energy, for the good and welfare of the State Board of Health; and

WHEREAS, On account of added duties imposed upon him by his recent appointment as Dean of the Medical College of the State of South Carolina, Dr. Lynch was forced to tender his resignation as a member of this Committee on May 16, 1945;

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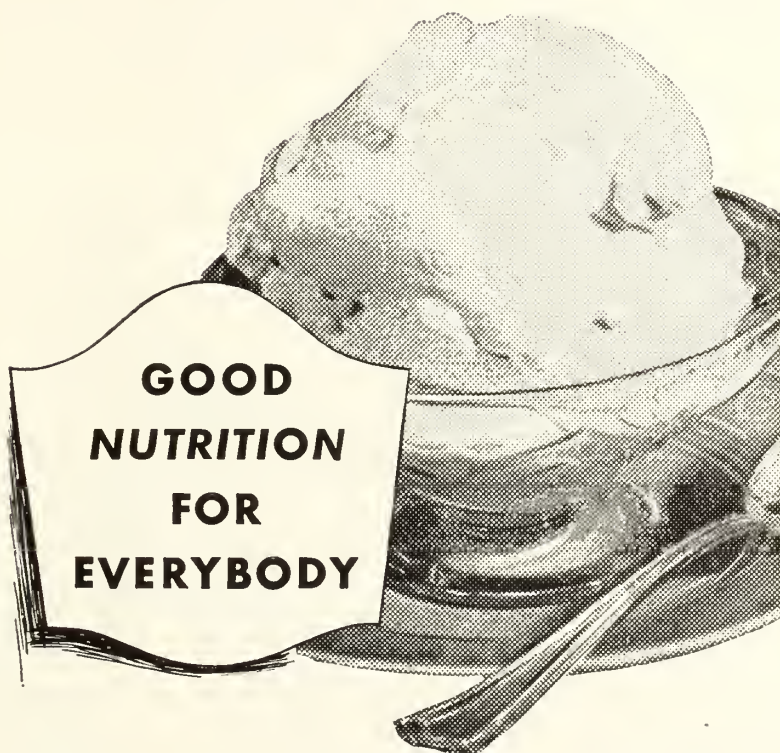
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NOW, THEREFORE, BE IT RESOLVED: That this Committee express to Dr. Lynch their deep appreciation for his counsel and guidance, not only as a member but as their Chairman, where in carrying out the many difficult duties of this office, he has so unselfishly served the interest of the general public of South Carolina;

BE IT FURTHER RESOLVED: That this Resolution be permanently recorded in the minutes of this Committee, a copy sent to the Editor of the Journal of the South Carolina Medical Association, and a copy sent to Dr. Lynch.

TWO NEW APPOINTMENTS IN COUNTY HEALTH DEPARTMENTS ANNOUNCED

Dr. Paul A. Woods Health Officer of Aiken County

Dr. Caroline H. Callison to Assist in Several Counties

Dr. H. Grady Callison, Director of Local Health Service for the State Board of Health, has announced two new appointments in County Health Departments.

Dr. Paul A. Woods, formerly Assistant Director of the Richland County Health Department, was appointed Acting Health Officer of Aiken County as of July 16 to replace Dr. C. P. Pope, who resigned to accept another position.

Before coming to the State Board of Health, Dr. Woods interned at the Washington Sanatorium and Hospital, Takoma Park, Washington, D. C. He received his degree in medicine from the College of Medical Evangelists, Los Angeles, California, in 1943.

Dr. Caroline H. Callison, who for the past four years has been serving as a County Health Officer in Alabama, has accepted an appointment, effective August 1, to assist in several Piedmont County Health Departments, with headquarters in Greenwood.

Dr. Callison is the daughter of Dr. and Mrs. H. Grady Callison, of Columbia. She graduated from Coker College, Hartsville, S. C., with a B.S. degree, and in 1939 she received her degree in medicine from the Medical College of the State of South Carolina. She served a two-year internship in the Crawford W. Long Memorial Hospital, Atlanta, Ga.

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The cause of rheumatic fever and the mode of its transmission are not known. Treatment, therefore, has been directed, in part, toward efforts to control the disease by keeping the patient at rest. Sulfonamides and salicylates are used to help prevent subsequent attacks, the patient shielded from exposure, and fed a nutritious diet. Physicians are constantly helping in the solution of this problem by reporting their clinical observations. The need is to determine the cause and discover a drug, vaccine or serum to prevent or combat it. Until that occurs, the laity should be educated to watch for the symptoms, especially in children, and to secure prompt medical attention.

To help in this education we have prepared a pamphlet—"Watch Your Health"—which gives facts, simply stated, about this and six other serious diseases. Copies for distribution to your patients available on request.

*U. S. Summary of Vital Statistics, 1942.

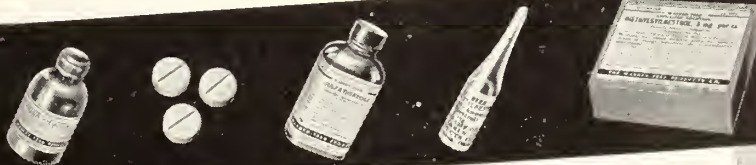
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DEATHS

Francis L. Parker

Dr. Francis L. Parker, professor of chemistry at the Medical College of the State of South Carolina, died on the morning of August 20 at a hospital in Hendersonville, N. C.

A native of Charleston, Dr. Parker spent most of the years of his life in his home town. He was particularly well qualified for the work of teaching for his preparation consisted of securing a B.S. degree from the Citadel (1894), an A.B. degree from the Univ. of S. C., an M.S. degree from the Univ. of Chicago, a degree of Ph.D. from the University of Chicago, and an M.D. degree from the Medical College of the State of S. C. (1909). In addition to teaching at his alma mater he also served for a period as its Vice-Dean and Dean.

His knowledge and his keen sense of humor made him a most popular professor and many are the stories which his former students tell of his wit and wisdom. His friends were counted by the thousands and their hearts were saddened at the news of his death.

Dr. Parker is survived by his widow and one daughter.

David B. Jackson

Dr. David B. Jackson, 87, of Greer, died on August 7, following two years of declining health. Dr. Jackson was one of the oldest physicians of South Carolina having practiced his profession for 58 years. A graduate of Emory Medical College (1885), Dr. Jackson practiced in Greenville County until two years ago when his health failed. He is survived by one daughter and two sons.

NEWS ITEMS

Dr. Larue Medlin, who has been employed by the Charleston Shipbuilding and Drydock Company, has opened an office at Avondale and will do general practice.

Major James W. Fouche (Columbia) is back in the United States after twenty-seven months overseas. Major Fouche was with the 95th Evacuation Hospital Unit.

Lt. Col. Hugh Smith and Lt. Col. C. H. Fair, both of Greenville, have received discharges from the Army and plan to reopen their offices in the early fall.

Major John M. Pratt of Columbia, now serving with the 225th Station Hospital in Italy, has recently been promoted from the rank of Captain. Before entering the service Major Pratt was a member of the staff of the South Carolina State Hospital at Columbia.

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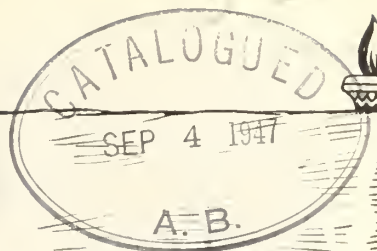
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The Journal of the South Carolina Medical Association

OCTOBER, 1945

VOL. XLI, NO. 10

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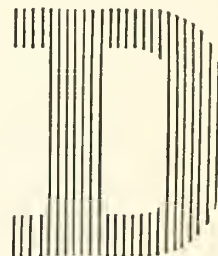
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1. Am. J. Dis. Child. 66:1 (July) 1943.
2. Nebraska State Med. J. 29:15 (Jan.) 1940.



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THE JOURNAL

of the

South Carolina Medical Association

VOLUME XLI

October, 1945

NUMBER 10

Treatment of Extensive Second and Third Degree Burns

DANIEL L. MAGUIRE, JR., M.D., CHARLESTON, S. C.

Burns may be classified according to:

1. ETIOLOGY:

(a) **THERMAL—**

(1) Dry heat—exposure to actual flame.

(2) Moist heat—exposure to boiling liquids, live steam, etc.—known as scalds.

(b) **ELECTRICAL—**caused by

(1) Electric currents.

(2) X-ray, radium.

(c) **CHEMICAL—**contact with strong acids and alkalis.

2. DEPTH OF BURN:

(a) 1st degree—erythema of skin without necrosis.

(b) 2nd degree—characterized by blister formation. Destruction of epithelium down to the germinal layer.

(c) 3rd degree—destruction extends into or through the germinal layer of the skin, often into the subcutaneous tissue and even into the underlying fascia or muscles. The tissue is usually greyish black in color, hard, leathery, and sometimes even actually charred.

3. EXTENT:

Usually spoken of in percentage of the total skin surface area of the body—such as 20%, 30%, 40%, etc.

GENERAL PATHOLOGY:

Deaths from burns are due either to shock or infection. It is axiomatic that those who die in the first forty-eight hours die of shock, those who succumb later, die of infection.

(a) **SHOCK**—although almost certainly there is some neurogenic element present in the formation of shock seen in cases of extensive burns, the predominant etiological factor is the loss of plasma in large quantities from the burned surface. The loss of plasma and consequently the depth of shock is proportionate to the extent of the burned areas.

portionate to the extent of the burned areas.

(b) **INFECTION**—occurs in a large percentage of cases no matter how vigorously treatment is directed toward its prevention. Infection of the burned areas usually begins to evidence itself about the fifth to the tenth day, and is usually due to staphylococcus streptococcus, pyocyanus or a mixed infection. Secondary complicating infections such as terminal pneumonia or septicemia is commonly the cause of death in severely burned patients whose resistance is very low.

CLINICAL MANIFESTATIONS:

Cases of first degree burns—most commonly sunburn—are painful and tender over the involved areas—but seldom are any marked systemic manifestations present. Second and third degree burns should be considered together, since, in extensive burns, there are some elements of both types present in varying extents. Typically, the patient may have areas of second and third degree burns over 30%-40% of the body surface. These patients are usually rushed to the care of a physician as soon as humanly possible.

Upon arrival, these are either in deep shock or will soon be in shock—depending on the time elapsing between the burn and the time at which treatment is begun. Those in shock evidence the classical picture of that syndrome. They may be restless and anxious or dull and apathetic. The skin is pale, greyish, cold and moist. The pulse is rapid and of poor volume, the blood pressure is low, the temperature subnormal. Blood studies show that, due to the excessive loss of plasma, there occurs almost immediately a hemoconcentration, the degree being proportionate to the extent of the burns. The red blood cell and white blood cell counts and hemoglobin are abnormally elevated. Blood chlorides and plasma proteins are lowered due to the loss of these substances from the burned areas.

Later, during the stage of infection, the clinical

picture is changed. The fever ranges high, anorexia is marked, the patient loses weight and strength steadily, and a marked secondary anemia appears. As sloughing continues, often for weeks to months, and infection of the necrotic areas persists, edema due to hypoproteinemia and decubitus appear. The clinical picture is that of sloughing, cachexia, infection and malnutrition. Many patients, at this, the lowest ebb of their resistance, are carried off by septicemia or pneumonia.

PROGNOSIS: As with many other diseases, the aged and young children succumb much more rapidly to severe burns than do young adults. From the standpoint of loss of life, the extent of the burn is more significant than the depth. The depth of the burn is more of an index of the amount of scarring, contracture and disability to be anticipated later.

TREATMENT:

The treatment of burns may be classified into (1) immediate and (2) late, and of these, each may be further sub-classified into (a) local and (b) general.

I.—IMMEDIATE

(a) **GENERAL**—In severe extensive burns, even if shock is not present, it should be anticipated. The attention to shock or impending shock should take precedence over the treatment of the burned areas.

As with any other patient in shock, morphine should be administered in a liberal dose immediately. The burned areas should be covered for the time being with sterile sheets. Fluids should be begun at once—plasma preferably, but if this substance is not immediately available, 5% glucose in normal saline should be employed in the interim until the plasma can be obtained. Patients in whom it is at once obvious that large amounts of fluid will have to be given intravenously over a prolonged period, do better by having the saphenous vein cannulated at the ankle, and a continuous drip begun at the outset. This eliminates the necessity for repeated painful, tedious searches for collapsed veins later.

Plasma infusions must be continued in large quantities during the first 48 hours, the period of shock. Many rules have been devised as to the amount of plasma which should be administered, these rules based on the age of the patient, the extent of the burn, the degree of hemoconcentration, etc. However, we believe that it is far better to regulate the dosage of plasma according to the clinical response of the patient and the state of the vascular bed. Plasma should be continued until it is obvious that plasma loss has ceased, and the stabilization of the vascular bed precludes the possibility of the patient lapsing back into shock. This decision can be arrived at safely only by repeated frequent observations of the blood pressure and pulse, and repeated estimations of the red blood count and hemoglobin values—the most accurate indices of the degree of hemoconcentration. In our experience, the falling drop test — a measure of the specific gravity of the blood in hemo-

time consuming to be practical in the average case. concentration — has proved to be too intricate and We have used adrenal cortical extract frequently in severe burn cases, and we believe it definitely contributes to and hastens stabilization of the vascular bed.

(b) **LOCAL**—After the patient has had morphine for comfort and sedation, and after fluids have been begun and are running in satisfactorily, then our attention should be directed to the local treatment of the burned areas. Our aim is two fold—(1) to stop the loss of further plasma, and (2) to prevent or minimize infection of the burns. In extensive burns, this is not a job for one's office or the emergency room. These burns are open wounds, and they should be treated as such. The patient is taken to the operating room, and after the team is properly attired in mask, gown and gloves as for any other major surgical procedure, cleansing and debridement of the involved areas is begun. We prefer not to use general anaesthesia because of the patient's precarious general condition. If the work is done gently, usually the initial dose of opiate is sufficient. The lesions are cleansed with a soft cloth and white soap and sterile water. We believe this is better than a scrubbing brush and green soap, since it is obvious that no matter how vigorously one scrubs, and no matter how strong the soap, all of the organisms cannot possibly be removed, and it would seem that it is wise not to traumatize the areas further and make them less able to combat any remaining bacteria. Blisters are punctured, and any loose and obviously devitalized tissue is debrided away. The burns are then lightly sprinkled with sulfathiazole powder and a bland ointment applied to them. We have used at one time or another vaseline, boric acid ointment, cod liver oil ointment and sulfathiazole ointment, but have failed to see where one preparation offers any advantage over the others as to minimizing infection and stimulating tissue repair. After the ointment dressings are in situ, they are then reinforced voluminously with about four inches of cotton gauze pads or sterile mechanics waste to exert pressure uniformly over the area, and the part is wrapped snugly, preferably with elastic bandages. These dressings are left undisturbed for seven to ten days, at the end of which time they are changed and replaced. Not infrequently, a majority of the second degree burned areas will be found at the end of that time to have already been covered with epithelium. Burns around the genitalia and perineum obviously cannot be treated with pressure dressings. We have decided that saline dressings applied locally and changed as necessary give the most satisfactory result.

It is not our purpose to go into a discussion of the virtues and faults of tannic acid, triple dye, sulfadiazine spray and other methods which were commonly employed prior to pressure dressings. Suffice to say that we have found that pressure dressings give the best result as far as minimizing infection

and facilitating tissue repair, and we feel that this method of treatment simplifies the nursing care of these patients which is always such a problem.

II—LATE

(a) GENERAL—The keynote of treatment is good nursing care and supportive measures until the areas are either healed or are in condition satisfactory for grafting. The patient should be fed a high caloric, high protein diet, he should be turned frequently, and the bed linen should not be allowed to become wrinkled or excessively soiled with exudate. The perineum should be cleansed carefully after each bowel movement to prevent feces getting up under the dressings. Medications should include iron, vitamins, and amino acids given orally or, if necessary, intravenously. Probably the most important single item of treatment is whole blood, given repeatedly and frequently, to combat the marked secondary anemia which always develops. If obvious infection occurs as evidenced by purulent exudate over the burned areas, fever, chills, prostration, etc., then chemotherapy with the sulfonamides or penicillin or both should be administered.

(b) LOCAL—We can dismiss first degree burns by advising the application of a bland, anaesthetic ointment such as *Butesyn Picrate*, 1%, (ABBOTT) locally.

Second degree burns will regenerate their own epithelium from the intact germinal layers, sweat glands, and surrounding undamaged skin. Ointment dressings are left on until the areas are completely epithelialized. It is not necessary, and is probably undesirable, to dress the lesions more than once every week or ten days. Obviously, rigid sterile technique should be carried out during the dressings to prevent contamination and secondary infection.

The problem cases are those with extensive third degree burns. All of the devitalized tissue, often down into the fascia and muscles, must be cast off and replaced with healthy granulations before repair can start. This process often takes weeks to months during which time the patient is clinging to life precariously. Practically always, the necrotic sloughing tissue is infected, and large amounts of purulent exudate is present. These patients all have to be grafted, since there are no dermal elements remaining from which epithelium can be regenerated. Grafting should be begun at the earliest possible moment that the tissue will accept a graft, and continued frequently to prevent or minimize contractures. Every time the dressings are changed, all loose, necrotic tissue should be cut away. Some experienced observers advise putting these patients under an anaesthetic and debriding

radically down to healthy tissue to speed up the stage of sloughing and get rid of the dead infected tissue at once. While the area is being prepared for grafting, continuous wet dressings of normal saline, boric acid or $\frac{1}{2}$ strength Dakin's solution clean up the exudate and minimize infection. When the necrotic slough has been replaced by red, healthy granulations, no time should be lost in starting to graft. The presence of a persistent purulent exudate indicative of a low grade infection is no contraindication to grafting.

The type of graft most commonly and most successfully used in these extensive burn cases is the "thick split" graft which is taken from any available skin surface, and which is carried down to but not through the germinal layer. These grafts can now be cut off in large sheets at a predetermined depth with the use of the Padgett Dermatome. They are then sutured in place over the area to be grafted, or more lately, stuck to the area with the use of a thrombin "glue." Pressure dressings are then applied to the grafted area and ointment dressings to the donor sites. At the end of ten days, if all has gone well, the grafts will have "taken" and the donor areas will have healed. Further grafting is then done until all of the areas are covered. It is usually wise, where multiple grafts will be necessary, to cover the region of the joints first to prevent contractures. While grafting is being carried out, it is important to splint the extremities in a neutral position to insure complete rest of the part, and to forestall foot drop and contractures. Although homografts have been used as a temporary measure to tide an extensively burned patient over a critical period, we have preferred to take autografts repeatedly from the same areas if necessary—in one case as many as three times. In the hands of the average surgeon, the Dermatome is far superior to the Blair knife, since it takes a tremendous amount of experience to cut free hand a large uniform graft such as can be obtained with the Dermatome by a surgeon who is called on to do plastic work only occasionally. In our opinion, there is no place for pinch grafts in these kinds of cases. They are unsightly, tedious, time consuming, and because of the length of time required to cover a large area with these, contractures often develop before the lesions can be covered with skin. After the burns are covered with skin, passive motion of the joints should be begun at once, and soon thereafter the patient should be encouraged to start active motion. He should then be referred to a physiotherapist for vigorous active and passive motions, exercises to facilitate use once again of disabled muscles and joints, hydrotherapy and massage.

Rocky Mountain Spotted Fever or Tick Fever in South Carolina

M. W. BEACH, M.D., AND B. O. RAVENEL, M.D.
CHARLESTON, S. C.

We thought that it might be worth-while to remind the physicians of South Carolina of the possibility of this disease and to report two proven cases, one in a white child and the other in a colored child.

Typhus fever, an acute infectious rickettsial disease, is common in South Carolina, but tick fever or Rocky Mountain spotted fever is almost unheard of in this section; not because of a sparseness of the tick family, but because of the apparent lessened infectivity and the lack of knowledge of its propagation, habits, distribution and the parts played in the production of this disease. On the other hand, murine typhus fever is a very common rickettsia disease and the one which is most frequently encountered in this area. In discussing rickettsial diseases it may be worth-while to remember that all pathogenic rickettsial are parasites of various arthropods (insects, ticks, mites). This pleomorphic organism establishes a close biological relationship with certain arthropods and invades the cellular structures of the vascular system as well as the gastro-intestinal tract. In Rocky Mountain spotted fever it is stated that even the cell nucleus is invaded.

This disease affects rural residents chiefly during the spring and summer months and is known to the farmer and stockmen as tick fever. However, their urban brothers often become victims of this disease for they frequently have jaunts into the country for recreation and return to the city with the unsuspected guests. It is believed that the Ixodoidea ticks are the only vectors capable of transmitting Rocky Mountain spotted fever. The common varieties are: (1) *Dermacentor Andersoni*, (2) *Dermacentor Variabilis* and (3) *Amblyomma Americanum*.

Tick fever has been reported in forty-two states. The greatest number in the western states but there are many cases reported in Maryland, Virginia and North Carolina and during the past fifteen years 39 cases have been reported in South Carolina. The mortality of this disease is from 18 to 28%.

In considering the symptomatology of Rocky Mountain spotted fever it may be worth-while to mention some of the common findings in this disease.

(1) The incubation period is usually from four to eight days which is followed by malaise, headache, anorexia, chilly sensations and aches and pains in the muscles.

(2) A sudden onset with fever from 102 to 105 which is a somewhat sustained type of temperature.

(3) May find indurated site with or without tick or history of contact with ticks.

(From the Department of Pediatrics, Medical College of the State of S. C., Charleston.)

(4) A rash which occurs about the fourth day and begins on face, neck, hands, arms, feet and legs and spreads centripetally. This rash is a discrete maculopapular type and is petechial in character, but in severe cases may become somewhat confluent. The eruption reaches its height in 2 or 3 days.

(5) The pulse is slow at first but later becomes very rapid.

(6) Intoxication, prostration and mental confusion are pertinent findings but vary with the severity of the disease.

(7) The white blood count is usually 12,000 to 30,000 but not diagnostic. Weil-Felix reaction is positive after the first week. After the first ten days the complement fixation test is positive in high dilutions. This is probably the most reliable laboratory test.

At times the onset may be confused with other acute infectious diseases such as typhoid fever, severe measles, meningococcal meningitis, purpura hemorrhagica, and septicemias. However, the main difficulty in differential diagnosis is found in eliminating typhus fever. Therefore, we should be mindful of the following facts.

(1) The onset of typhus is less explosive.

(2) The incubation period is longer.

(3) Typhus may occur in any season but is usually seen in late summer and fall.

(4) The rash appears first on the body and is more macular. It spreads in a centrifugal manner. It is seldom petechial in character and usually does not involve the mucous membranes.

(5) Flea and rat hazard should be considered.

(6) Typhus is more prevalent in urban than in rural sections.

(7) The white blood count is usually not so elevated.

(8) There is less intoxication, prostration, mental confusion and muscular pains.

(9) The complement fixation test is positive for Rocky Mountain spotted fever but negative for typhus.

(10) The prognosis is more favorable as indicated.

Treatment of Rocky Mountain Spotted Fever

(1) Bed comfort and hydrotherapy as indicated.

(2) Maintain at all cost hydration and electrolytic balance.

(3) Usually this can be more easily accomplished by parenteral administration of saline and glucose in physiological solution.

(4) Blood transfusions and plasma when necessary to maintain osmotic balance.

(5) Encourage the drinking of fresh fruit juices or other desirable cold drinks.

(6) The sulfonamides and penicillin may be considered but are of questionable value.

(7) Serum may be of value if given before the fifth day.

(8) Since this is an intracellular infection, medication which does not diffuse into the cell is of questionable value. This applies to rickettsial as well as the virus diseases.

Case Histories

(1) Case No. 38197. Ten year old white male who was admitted to Roper Hospital on May 1, 1945 with a chief complaint of fever and rash for one week. According to the history, the boy had become sick nine days before admission at which time he complained of epigastric pain and also pain in the bottom of the costal cage bilaterally. He became nauseated and vomited several times at the onset and began to run a high fever which according to the mother seemed to "go up and down." The day of onset he also had three loose stools but had had none since. He had no bowel movements for four days previous to admission. One week before admission, he complained of general malaise, muscular and joint pains and his mother noted a rash which she stated began on the arms and legs and spread over the chest, abdomen and face. The rash had continued to be present becoming more marked for two or three days and since that time had remained about the same. The history was obtained that all the water the child drank was city water. There was no history of ticks about the house or any tick bites. There was no history of any contact with rabbits. The father stated that they had had a dog which had been sick, apparently having mange and, also from time to time, ticks had been found on this animal. The father stated that it had been necessary to kill the dog about a week before the child had taken sick because of its poor condition. He also stated that there were some rats about the house and garage.

Physical Examination. Temperature 105.4. Pulse 144. Respiration 64. The patient was a well developed and fairly well nourished male who appeared acutely and seriously ill. He seemed to be moderately dehydrated. There was a discrete maculopapular rash over the entire body, face, extremities, including the soles of the feet and the palms of the hands. The rash was noted to be rather dense with lesions of 3 to 5 mm. in diameter, some of which appeared to have hemorrhagic tendency. The ears were negative. The eyes showed slight conjunctival injection. The nose was normal. The teeth were in fair condition with many carious teeth. There was no bleeding of the gums. Mucous membranes of the mouth showed evidence of the rash which was present on the body and there was a definite petechial or hemorrhagic tendency to these lesions in the mouth. The tonsils were absent. Pharynx was moderately injected. The lungs were clear to percussion and auscultation. Heart was regular and rapid. Apparently not enlarged. No murmurs were heard. The abdomen was soft and flat. The tip

of the spleen was palpable. The liver was palpable just below the right costal margin. There was marked tenderness in the left upper quadrant. The reflexes were slightly hypoactive. There was generalized muscular soreness in the extremities and the patient appeared to have some joint pains. The neck was not stiff.

Laboratory Examinations:

Urinalysis on 5-2-45 was essentially negative.

Blood Count—5-2-45:

R. B. C.—3.87

W. B. C.—9,750

Hgb.—11 gms.

Pmn.—81%

Lym.—15%

Mono.—4%

Polys show moderate toxic granulations.

Feces on 5-2-45 negative for ova and parasites.

Blood Wassermann negative.

Blood culture was negative.

Agglutinations on 5-2-45

E. Typhosa "H"	++++ in 1/160 dilution.
E. Typhosa "O"	Negative.
Paratyphoid A	Negative.
Paratyphoid B	Negative.
Proteus X-19	+ in 1/120 dilution.
Brucella abortus	Negative.

On 5-5-45 agglutinations for E. Typhosa were positive in dilutions of 1/2,560 and for proteus X-19 in a dilution of 1/1,280.

Specimen of serum was sent to the National Institute of Health in Bethesda, Maryland for examination with the following results:

Complement Fixation Tests:

Endemic Typhus: Positive in dilution 1/16.

Rocky Mountain spotted fever: Positive in dilution 1/4096.

Agglutination Tests:

B. proteus OX-19: Positive in dilution 1/320.

Course: On admission patient was started on penicillin—doses of 10,000 units every three hours subcutaneously and fluids were forced by mouth. Temperature gradually declined and on 5-10-45 reached normal where it remained until discharge. Patient continued to complain of muscular aches and pains which gradually decreased in severity and by 5-7-45 had no further complaints as far as this was concerned. On 5-3-45 it was thought that the rash had faded to some extent and on 5-5-45 it was noted that it had lost its red characteristic and the papules had assumed a brownish tint. On 5-7-45 the remains of the rash was a dark brown. On 5-10-45 the rash had almost completely disappeared. There was some slight desquamation in isolated areas. On

5-12-45 areas of hyperpigmentation were the only residua of the rash and there was some branny desquamation of the previously papular lesions. Patient was discharged on 5-12-45 having completely recovered from his illness, to convalesce at home.

(2) Case No. 38056, a four year old negro female who was admitted to the Pediatric Department of Roper Hospital on 4-18-45 with a chief complaint of "fever." The history obtained was that this child had developed a moderate cough two days prior to her admission which was followed by a high fever. She had been having some fever since the onset of the illness but it had become much higher on the second day. She had vomited twice the day before admission and had had no bowel movements for the past two days.

The past history revealed that the patient had had no immunizations. She had had pneumonia at the age of six months.

Physical examination at 6 P. M. on 4-18-45 revealed an acutely ill, somewhat lethargic, irritable negro female. Skin was hot and dry. The eyes and ears were negative. There was no nasal discharge. The tongue appeared red with many large prominent papillae. Tonsils and pharynx were acutely inflamed. Sub-maxillary nodes were palpable. The lungs were resonant throughout. No change in breath sounds was noted. There were occasional scattered rales over the lung fields. The heart was rapid and regular with a soft blowing systolic murmur in the pulmonic area. Abdomen—Liver palpable one and one-half fingerbreadth's below the right costal margin. Tip of the spleen was palpable. There were no masses or tenderness. Genito-Urinary system was negative. Reflexes were physiological.

Two hours later another examined noted that the hands and feet seemed reddish and that there was a suggestion of a reddish hue over the body. There were a few small, raised, pale papules on the abdomen especially in the left upper quadrant. A few papular lesions were also seen on the arms, legs and face. At 12:30 A. M. on 4-19-45 this examiner again made a note that the rash was more prominent over the arms, legs and face, and that there were a few lesions on the abdomen and none on the chest. The rash was papular in type and pale in appearance and appeared to be coming on rapidly. No Koplik spots

were noted. At 9 A. M. on 4-19-45 the rash apparently had receded slightly but was easily seen covering the face, arms, and legs with a moderate amount on the abdomen, and it could also be seen on the palms of the hands and the soles of the feet. The patient was semi-stuporous with a moderate stiff neck and a positive Brudzinski. Kernig was negative. She complained of pain on flexion of the neck. Throat was markedly inflamed and there was a small amount of exudate on the left tonsil. Lumbar puncture was done and 30 c. c. of crystal clear fluid was removed under no increase in pressure. At 10:30 P. M. on 4-19-45 the temperature rose to 102.6 and the patient appeared more stuporous. The rash had again become prominent and it was described as having a rather shotty feel. The patient continued to run a rather septic type of temperature with an afternoon rise. On 4-24-45 it appeared that the temperature was beginning to drop to some extent. Penicillin was started on 4-25-45 but apparently had no effect upon the course of the disease. The temperature dropped to normal gradually and reached normal on 4-29-45 where it remained until the patient was discharged from the hospital on 5-12-45. The rash began to disappear on 4-26-45 and disappeared fairly rapidly. On 5-7-45 it was noted that there was desquamation or scaling over all areas where the papular lesions had been present. On 5-9-45 pigmented areas were all that remained of the previous papular rash. Desquamation of the soles of the feet appeared on 5-11-45. Patient was apparently very happy and in excellent condition on discharge from the hospital.

Laboratory Examinations:

Urine showed a trace of albumen on admission. Otherwise, it was negative at all times.

	4-18-45	4-19-45	4-23-45
Blood			
W. B. C.	22,500	22,600	20,600
R. B. C.	4,700,000		
Hgb.	10½ gms.	10½ gms.	9½ gms.
Pmn.	48%	59%	61%
Non. Fil.	25%	26%	
Lym.	52%	41%	39%

Feces on 4-19-45 was negative for ova and parasites.

Blood Wassermann & Kline was negative.

Blood Culture was negative.

	4-19-45	4-23-45	4-29-45
Agglutinations			
E. Typhosa "H"	Negative	Negative	+ in 1/20
E. Typhosa "O"	++ in 1/20	++ in 1/20	++ in 1/20
Paratyphoid A	Negative	Negative	Negative
Paratyphoid B	Negative	Negative	Negative
Proteus X-19	++++ in 1/20	++++ in 1/20	++++ in 1/20
	++ in 1/40	+++ in 1/40	++ in 1/40
		+ in 1/80	+ in 1/80
Brucella abortus	Negative	Negative	Negative

On 4-28-45 a specimen of serum was sent to the National Institute of Health in Bethesda, Maryland for examination with the following results:

Complement Fixation Tests:

Endemic Typhus: Negative.

Rocky Mountain spotted fever: Positive in dilution 1/2048.

Agglutination Test:

B. proteus OX-19: Positive in dilution 1 80.

The patient returned to the Out Patient Clinic on 6-4-45 and at that time we were unable to obtain

any history from the mother of the child having had any contact with ticks. However, she stated that there had been a kitten at home which had died about a week after the child was admitted to the hospital. Cause of death was not known.

The patient had been progressing satisfactorily since discharge from the hospital two weeks previously and appeared to be in good condition. There were definite hyperpigmented areas where the eruption had been present which were especially prominent on the thighs and legs and some could be seen on the abdomen and upper extremities. Patient was discharged and has not returned since.

Subacute Bacterial Endocarditis in a Child Case Report

R. H. CHAPPELL, M.D., GREENVILLE, S. C.

B. J. C., white female. Age at death: 10 years. 10 years.

Case Number 5917.

Path. Number A-45-33.

First Admission: April 9, 1943. The patient was brought by her father who complained that she staggered when walking. This condition had started seven weeks prior to admission and had progressed so that the child was unable to keep still when awake and four days prior to admission was unable to talk.

There was the history of the usual childhood diseases including diphtheria but no history of rheumatic fever.

Family history was irrelevant.

Physical examination showed a poorly nourished, pale child who moved her limbs constantly and could not talk. The heart rate was 108 and regular. There was a systolic murmur at the apex. Otherwise, the physical examination was negative.

Admission urine was negative; hemoglobin was 10.5 grams; corrected sedimentation rate was 52 mm. Electrocardiogram showed a deep R-3 with inversion of T-3 and T-4.

A diagnosis of Sydenham's chorea was made.

The patient was treated with complete bed rest, salicylates, sedatives and vitamin preparations.

Dental consultation on May 19 showed decayed

lower molars and extraction was advised. There is no record of this recommendation having been carried out. On July 29, a tonsillectomy was done.

The chorea did not improve markedly on the treatment given but the temperature became normal and she was discharged by ambulance on her 122nd hospital day.

Second Admission: July 24, 1945. After discharge she improved only slightly and still had attacks of chorea. Four weeks before her final admission she again had a very severe attack accompanied by high fever. She vomited frequently but had no diarrhea. Her father said that she occasionally had hot, swollen joints. She complained of pains in the legs, hips and shoulders. She also had dyspnea on slight exertion and frequent nosebleeds. Fever continued until her second admission although there was some improvement in the chorea.

Physical Examination: The patient was a poorly developed and nourished white girl. There was a loud blowing systolic murmur over the apex, heard less distinctly at other valve areas. Heart rate was rapid and a precordial thrill was palpable. There was also a loud diastolic murmur at the apex. Lungs were clear. Remainder of the physical examination gave no help.

Leukocyte count on admission was 25,450 with 68% neutrophils and 32% lymphocytes. Urine showed 1 plus sugar. There were 30 to 35 pus cells per high power field. Agglutinations with the usual

febrile antigens were negative. On July 28, urine showed 5 to 10 pus cells per high power field. Corrected sedimentation rate was 30 minutes in one hour by the Wintrobe method.

During hospitalization the patient was given penicillin in doses of 15,000 to 50,000 units, subcutaneously and intramuscularly, a total of 735,000 units over a period of six days. She was also given salicylates, vitamin concentrates and adequate fluids.

Temperature on admission was 103 degrees and fluctuated between 99.5 degrees and 103.5 degrees until shortly before death when it rose to 107 degrees. She was somewhat drowsy during most of her hospitalization and for this reason was regarded as a possible typhoid patient. She complained occasionally of pains in her knees and hips. There were no choreiform movements. She continued drowsy and could not be aroused the day before death. Pulse became very weak and respiration shallow until expiration on July 30, 1945.

POST-MORTEM REPORT:

Anatomical Diagnosis:

1. Large, friable vegetations on the mitral valve cusps.
2. Thickening of the chordae tendineae of the mitral valve.
3. Multiple small emboli all over the body.
4. Focal embolic nephritis.
5. Cloudy swelling of the liver.

External Examination:

The body is that of a fairly well developed, somewhat emaciated white female 122 cm. long. There are several small red spots about 1 mm. in diameter in each conjunctiva. Examination of the eye-grounds shows a hemorrhagic area lateral to the disc. The left eye shows a suggestion of the same type of lesion but this is not so clear. Except for emaciation the remainder of the body shows no lesions.

Pericardial Cavity: The sac contains about 75 cc. of clear, straw-colored fluid. There are a few petechiae on the epicardial surface.

Pleural Cavities: Serous surfaces are smooth, transparent and glistening except for a few petechiae on the visceral surfaces. There is no appreciable free fluid.

Peritoneal Cavity: Surfaces are smooth, transparent and glistening except for a few red spots visible through the serosa of the gut. The diaphragm is at the third intercostal space bilaterally. The appendix hangs free in the cavity and is not inflamed. There are about 300 cc. of clear, straw-colored fluid.

Heart: Weight: 180 grams. The serous surfaces

show the petechiae mentioned above. Section through the myocardium of the left ventricle shows a mottled yellowish and red color and seems to be considerably degenerated. The mitral valve has on its posterior cusp a large thrombus measuring 1 x 1½ x 2 cm. On the anterior cusp is a similar thrombus measuring 0.5 x 0.5 x 2 cm. These fairly effectively block the passage of blood from the left atrium to the left ventricle. Two or three of the chordae tendineae of the mitral valve are considerably thickened.

Aorta: Shows no lesions.

Lungs: Weight: left 140 grams, right 190 grams. Surfaces contain petechial hemorrhage mentioned above. In the posterior portions, near the base, there is a small amount of patchy redness. Sections show a few petechiae throughout the tissue.

Liver: Weight: 1100 grams. Surfaces are smooth, brownish red and glistening. The edge is fairly sharp. Cut section shows normal lobular markings with a slightly bulging surface.

Gallbladder: This contains about 10 cc. of thin, amber bile which flows freely from the ampulla on pressure.

Spleen: Weight: 125 grams. This shows several infarcts on its surface which are visible on section as small wedge-shaped areas of pallor.

Gastrointestinal Tract: This is normal throughout except for small red spots in the wall about 5 mm. across, the majority of which have in the center a small, firm yellowish nodule about 1 mm. in diameter. These are distributed throughout the small and large intestines.

Pancreas: Normal in size, shape and consistency. Cut section appears normal.

Adrenals: Normal in size, shape and consistency. Cut section appears normal.

Kidneys: Weight: 125 grams each. The capsules are thin and pliable and strip easily leaving a somewhat pale pink surface having numerous petechiae and some rather large infarcts. Each of these is visible on section as a wedge-shaped area of pallor surrounded by a small red zone. Otherwise, the cortex and medulla are normal. Calyces, pelves and ureters appear normal except for a few petechiae in the mucosa.

Bladder: This contains about 500 cc. of clear, straw-colored urine. Mucosa shows a few scattered petechiae.

Female Genitalia: Normal throughout.

MICROSCOPIC DESCRIPTION:

Myocardium: The muscle is infiltrated with polymorphonuclears in the grossly degenerated sites and many of the muscle fibers are swollen and fragmented

or altered to a basophilic, granular material. There is some connective tissue proliferation as is usually seen in Bracht-Wachter bodies.

Kidney: There are many small areas of neutrophilic infiltration and some frank abscesses. In the infarcted areas the interstices are packed with neutrophils and the parenchyma is necrotic.

Pancreas: One small abscess seen here.

Small Intestine: Section through one of the hemorrhagic areas of the small intestine shows one thrombosed vessel containing many polymorphs and having its wall and surrounding tissue infiltrated with polymorphs. This apparently represents the site of an embolus.

Spleen: This contains several large infarcts and a few smaller abscesses as does the kidney.

No section was made of the heart valve as the

whole heart was preserved as a gross museum specimen.

Culture taken at autopsy failed to grow any organisms.

COMMENT: This case is of interest for three reasons:

1. Subacute bacterial endocarditis is not common in children. Holt and MacIntosh report 15 cases in 50,000 admissions to the Harriet Lane Home.

Subacute bacterial endocarditis usually produces non-suppurative embolic lesions. Many of those in this case showed small amounts of suppuration. The history of rheumatic fever, the absence of a demonstrable primary source of infection, and the character of the valve vegetations makes the diagnosis of subacute, rather than acute bacterial endocarditis.

3. The patient failed to respond to penicillin, although some cures have been reported with the drug.



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The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price

Florence, S. C.

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OCTOBER, 1945

HOUSE OF DELEGATES

The annual meeting of the House of Delegates was held in Columbia on October 2 with a record attendance. Eighteen months had passed since the last meeting and there was of necessity a large amount of business to be handled, but under the combined leadership of Dr. W. R. Wallace (President 1944-45) and Dr. W. T. Brockman (President 1945-46) all matters were handled with efficiency and dispatch.

Since the official minutes of the meeting will not be in the hands of the members of Association until next month, we thought it advisable to mention briefly some of the more important decisions reached.

Returning Medical Officers. A special committee consisting of Dr. W. L. Pressly, Chairman, The President, the Chairman of Council, the Secretary, and Mr. M. L. Meadors as executive secretary was appointed to study the entire situation and to lay plans for helping our colleagues as they return from service and also for attempting to secure young physicians who have never been in practice to find suitable locations throughout the state. As plans and actions are taken by this committee, they will be published in this Journal.

Medical College Expansion Program. Council was requested to appoint a committee to study the entire question of the medical college expansion program and to make its report with recommendations to a call meeting of the House of Delegates before January 1, 1946. This committee is to consist of one member of the Association from each Judicial Circuit of the state (14 in all). The President and Secretary of the Association will serve ex officio, and Mr. M. L. Meadors will serve as executive secretary and counsel. It is hoped that through this method the entire membership of the Association will be afforded the opportunity to study the report which was presented at the meeting (this will appear in the November issue of this Journal) and to make its wishes known in the matter. After the adjournment of the House of Delegates, the Council met and selected the members of this highly important committee.

Hugh Smith, Greenville.

Public Relations. Realizing the great need for more and better public relations, the House of Delegates took a step which we think highly significant. Mr. M. L. Meadors, who has served so well as Executive Director of the Ten Point Program, had his title changed to Director of Public Relations and Counsel of the S. C. Medical Association. This will not only allow Mr. Meadors more room for his work but it will also extend his services to any committee or individual of the Association. So far as we know this is the first time that any state medical association has appointed a Director of Public Relations and we predict that it will have a highly favorable effect upon the public as well as upon our own members.

DUES. The annual dues of the Association were raised from \$10.00 to \$20.00. This was a unanimous action based upon a recommendation of Council. The House of Delegates was faced with the choice of continuing the work of the Ten Point Program and of Mr. M. L. Meadors with an increase in dues, or of continuing with our present dues and stopping the work. The wholehearted support of the proposal for increasing the dues is ample evidence of the worthwhileness of the Ten Point Program.

Election of Officers. The following officers were elected:

President-elect—Dr. James McLcod, Florence.

Vice-President—Dr. E. Marvin Dibble, Marion.

Secretary—Dr. J. P. Price, Florence.

Councilor First District — Dr. J. W. Chapman, Walterboro.

Councilor Fourth District — Dr. J. B. Latimer, Anderson.

Councilor Sixth District — Dr. J. H. Stokes, Florence.

Councilor Seventh District—Dr. C. R. F. Baker, Sumter.

Delegate to House of Delegates of A. M. A.—Dr.

PRESIDENT-ELECT

James C. McLeod, M.D., the new President-elect of the South Carolina Medical Association, has been an active member of the state body ever since beginning his surgical work in Florence in 1924. After graduating from Cornell University Medical College in 1922 and serving two years on the Second Surgical Division at Bellevue Hospital, New York City, Dr. McLeod returned to the Pee Dee section to become associated with his father, the late Dr. F. H. McLeod, one of the pioneer surgeons of South Carolina. It is interesting to note that the senior Dr. McLeod was President of the state association during World War I and that Florence County has had no other member of its profession elevated to this office until this year. Dr. James C. McLeod, a surgeon of outstanding ability, has acted as superintendent of The McLeod Infirmary for the past ten years, carrying it through a very significant expansion program involving both physical and professional facilities. He brings to the office of President-elect a vast amount of experience gained from his service as Councilor of the Sixth District for many years. Widely known throughout the state, and sincerely respected for the convictions which he is not afraid to express, Dr. McLeod can be expected to add color and sound leadership to the position of President-elect.

VICE-PRESIDENT

The Association paid a well deserved tribute when Dr. E. Marvin Dibble was elected Vice-President.

As a general practitioner who has served the community of Marion faithfully and well, as a member and then Chairman of the State Board of Medical Examiners, as a loyal worker for the good of the Association, and as an efficient physician and cultured gentleman, Dr. Dibble has endeared himself to a host of friends within and without the profession.

COUNCILORS

Two former members of Council, whose terms had expired, were elected to succeed themselves — Dr. J. B. Lattimer of Anderson and Dr. C. R. F. Baker of Sumter. Two new members were elected: Dr. J. W. Chapman of Walterboro to succeed Dr. F. G. Cain (who expressed a desire to have someone else in his place), and Dr. J. H. Stokes of Florence to succeed Dr. James McLeod who was elevated to the office of President-elect. Dr. Chapman is a general practitioner and Dr. Stokes an otolaryngologist.

DELEGATE TO A. M. A.

Dr. Hugh Smith was elected as the delegate to the House of Delegates of the American Medical Association. A former member and chairman of Council, a veteran of four years of service in World War II, a man with a keen intellect and with the gift for making friends, Dr. Smith can be counted upon to let the voice and wishes of the South Carolina Medical Association be heard and respected in the deliberative body of the American Medical Association.

DEATHS

Leonidas M. Stokes

Dr. Leonidas M. Stokes, 66, died at his home in Walterboro on September 23.

A native of Colleton County, Dr. Stokes received his undergraduate training at the University of South Carolina and University of Georgia and his medical degree from the Medical College of the State of S. C. (Class of 1907). After an internship at Roper Hospital he opened his office in Walterboro where he practiced medicine until his death.

In addition to his heavy practice Dr. Stokes gave untiringly of his strength toward promoting the interests of the Medical College and of his profession throughout the state. He was President of the S. C. Medical Association in 1938 and for many years was a member of the Board of Trustees of the Medical College.

Few physicians in South Carolina have been loved

more by his colleagues than was Dr. Stokes. His gracious manner, his Southern courtesy, his keen intellect and his winsome humor made him a physician of whom the profession is justly proud. The hearts of his friends are saddened by his passing but they are proud to have known him and to have claimed him as one of their own.

Joseph Barnett Workman

Dr. J. B. Workman, 67, died September 20 at a hospital in Greenwood as the result of an automobile accident. A graduate of the Medical College of the State of South Carolina (1907), Dr. Workman had practiced his profession at Ware Shoals for thirty-seven years. He is survived by his widow, one son, Major J. B. Workman, Jr., Army Medical Corps, and two daughters.

REFRESHER COURSE

(Sponsored by Alumni Association of Medical College)

October 31, November 1-2, 1945

Charleston, S. C.

WEDNESDAY, OCTOBER 31, 1945

9:30 A. M.

Dr. T. L. Montgomery of Philadelphia,
Professor of Obstetrics and Gynecology, Temple University, Associate Professor of Obstetrics and Gynecology, Jefferson Medical School.

Bleeding In Obstetrics

10:30 A. M.

Dr. Richard Kovacs, New York,
Professor of Physical Therapy, New York Polyclinic Medical School and Hospital; On the Staff of and Consultant to many hospitals in and around New York City. Author of several books on Physiotherapy.

Physical Medicine and the General Practitioner

11:30 A. M.

Dr. Charles F. McKhann, Director of Pediatrics, University Hospitals of Cleveland,
Professor of Pediatrics, Western Reserve University,

Advances in Pediatric Therapy

12:30-1:15 P.M.

Clinical Case Presentations:

- (1) Dr. L. A. Wilson—Discussion by Dr. Montgomery
- (2) Dr. Hillyer Rudisill—Discussion by Dr. Kovacs
- (3) Dr. M. W. Beach—Discussion by Dr. McKhann

1:30 P. M. Luncheon—Medical College Library

3:00 P. M.—Round Table Discussions:

Dr. Montgomery, Obstetrics—Auditorium

4:00 P. M. (1) Dr. Kovacs, Physical Medicine — Clinical Amphitheater

(2) Dr. McKhann, Pediatrics—Auditorium

5:00 P. M. Pathological Conference — Dr. Kenneth Lynch — Pathological Laboratory

9:00 P. M. Meeting of the Alumni Association, followed by informal smoker — Francis Marion Hotel

THURSDAY, NOVEMBER 1, 1945

BARUCH AUDITORIUM

9:30 A. M.

Dr. Hal Davison, Atlanta, Ga.,
Associate in Medicine, Emory University School of Medicine
His field is allergic diseases, especially of children,

Allergy and General Medicine

10:30 A. M.

Dr. Walter Alvarez, Rochester, Minn.,
Professor of Medicine, University of Minnesota (Mayo Foundation), Consultant, Division of Medicine, Mayo Clinic; Outstanding Gastroenterologist, best known for his writings on "Nervous Indigestion."

New Developments in Gastroenterology

11:30 A. M.

Dr. Robert McIver, Jacksonville, Fla.,
Jefferson Medical School 1916; Urologic Surgeon for fifteen years. Has done outstanding work on nephropexy
Abdominal Pain and Non-Calculus Obstruction of the Upper Urinary Tract — Diagnosis and Surgical Management

12:30-1-15 P. M.—Clinical case presentations:

- (1) Dr. Wm. H. Kelley—Discussion, Dr. Hal Davison
- (2) Dr. Douglas Remsen—Discussion, Dr. Walter Alvarez
- (3) Dr. James Ravenel—Discussion, Dr. Robert McIver

Round Table Discussion

3:00 P. M. Dr. Davison—Allergy—Clinical Amphitheater

4:00 P. M. Dr. Alvarez—Gastroenterology—Auditorium

5:00 P. M. Dr. McIver—Auditorium

8:00 P. M. Founder's Day Banquet—Francis Marion Hotel

Speaker—Dr. Walter Alvarez, of the Mayo Clinic,

The Emergence of Modern Medicine from Ancient Folk-ways

The Southern Group of Allergists will have luncheon at Henry's at 1:30 P. M.

FRIDAY, NOVEMBER 2, 1945
BARUCH AUDITORIUM

9:30 A. M.

Dr. Jefferson Browder, Brooklyn, N. Y.,

Clinical Professor of Surgery, Neurology and Psychiatry, Long Island College of Medicine; Neurological Surgeon to numerous hospitals in New York District

Surgery For Pain

10:30 A. M.

Dr. Jean Verbrugge, of Brussels, Belgium,

Professor of Orthopedic Surgery, University of Brussels, Belgium,

Basic Principles of Fracture Surgery

11:30 A. M.

Dr. John L. Lockwood, New Haven, Conn.,

Associate Professor of Surgery, Yale University; Graduate of Harvard. Formerly on teaching staff of University of Pennsylvania. Special work on Chemotherapy and Blood Substitutes,

Recent Advances in Prevention and Treatment of Surgical Infection

12:30 P. M. Clinical Cases:

(1) Dr. F. E. Kredel—Discussion by Dr. Browder

(2) Dr. F. A. Hoshall—Discussion by Dr. Verbrugge

(3) Dr. D. L. Maguire—Discussion by Dr. Lockwood

3:00 P. M.

Meeting of the State Fracture Committee, College of Surgeons, Auditorium

Program on Fractures, and talks by Dr. Browder and Dr. Lockwood



The Ten Point Program

M. L. MEADORS, EXECUTIVE DIRECTOR AND COUNSEL

THE MATTER OF PUBLIC RELATIONS

In line with current efforts being made by the Medical Society of New Jersey toward fostering public relations of the profession, a timely and thought-provoking editorial appeared in the August issue of its Journal, pointing out that the objective of the program is to secure and retain the good will of the people toward organized medicine in general and toward the Medical Society of New Jersey in particular. The writer suggests that there is a great deal of a positive nature required of the profession itself. For instance, to foster good public relations a thorough knowledge and sincere interest in the problems of the state, the counties, and the various social groups is necessary. Required also is an understanding of human relations, human reactions, and it is essential that, "In our own thinking we keep pace with social progress and that we learn to properly interpret public opinion. If we do not develop the ability to do these things, we may meet with abject failure."

The writer's next observation is one which we trust the members of the profession in South Carolina will keep in mind in their consideration of the Ten Point Program:

"Good public relations are not necessarily effective today or tomorrow. It requires a long range program which may show favorable effects years hence, not affecting medicine today or tomorrow but medicine of the future. It requires forward looking study, research and experiments. Its future effects should point the way for organized medicine if we ever reach the point where we can go no further without changing our direction."

Of utmost importance, as the editorial states, is the manner in which the position of the medical profession is presented to the public. This must be from the standpoint, not of the welfare of the medical profession itself or of the individual physician, but rather from the standpoint of promoting and protecting the welfare of society in general. In some of our recent remarks to various groups we have attempted to stress the fact that while the South Carolina Medical Society obviously and admittedly is interested in the welfare and desires first to promote the interest of its members, we realize the fact that the surest and most lasting results along this line can be obtained through promoting the welfare and interest of society at large. If the great body of society prospers, the profession prospers. What is good for the public economically and politically is, in the long run, good for the profession. In pro-

moting cooperation, health insurance, hospital care, medical education and other related subjects, the health and general welfare of the public is being considered and will ultimately be improved. The reaction upon the profession itself will almost necessarily be favorable, though it may take many years to present concrete proof of this fact.

The average lay individual is no more interested in the problems of the individual physician than is the individual physician interested in the problems of the lay individual. To assume otherwise would be to adopt a conceit which would be unworthy of physicians. The profession has been held in the highest esteem and has been the object of the greatest respect by the public. But the moment the public is convinced that this esteem and respect are undeserved by any substantial number of the members of the profession, or if the time should come when the public at large should reach the conclusion or should be persuaded to the belief that the selfish interest of the profession is opposed to the advancement and welfare of society at large, the esteem and respect would change overnight to an attitude of open hostility and the results would be far reaching.

Taking up again the thought of the New Jersey editorial writer: "The most effective factor in good public relations is not the result of a formal public relations program, but the sum-total effect of many small acts performed by individual physicians for the benefit of other individuals or groups, which stimulates among those individuals or groups a sense of respect for the individual physician as a member of the organized profession.

"Medicine is now faced with a social and economic problem which we cannot delegate to anybody else for solution. To solve the problem organized medicine must make a contribution which will advance present socio-economic knowledge and we must let general society know of the contribution we are making in their behalf. We must demonstrate our worth to society, that we are good, that we do good and that what we do accomplish as a free and independent profession is to the best interest of a free society."

Such an objective cannot be attained by a policy of simple opposition alone, to what some parts of the public sincerely believe is best. Any policy to promote public relations, in order to have even a remote chance of lasting success, must include as essential parts of the program, contribution of positive ideas and activities, a spirit of cooperation, a willingness to consider the interests of society on all levels — not simply on those levels where we find

our individual business or social contacts, and constant realization that the public must remain convinced that we seek the mutual welfare and benefit of the profession and the public alike.

THE BLUE CROSS ACT

Although to date the Blue Cross measure for which we worked and fought long and hard from January to the first of May has not yet become law, reports emanating from the Governor's office within the last two or three weeks appear to indicate that it may become law in January, 1946. The newspapers of September 4th carried an Associated Press dispatch stating that the Governor has said, "The measure will be signed next January." The language is a little ambiguous in that it states that, "The Governor said he would wait until the legislature convenes, when he said he would ask for some amendments to the bill before signing the measure."

This would indicate that signature of a Blue Cross Enabling Act might still be contingent upon the addition of amendments on which the Governor appears to insist. He has never pointed out specifically what these amendments are, and nobody else seems to be aware of the "serious defects" to which he refers.

On the other hand, the Governor is known to have written to more than one individual within the past two or three weeks stating that he intends "to sign this" measure on the first day of the meeting of the General Assembly. These statements leave no doubt that the Governor has said that he will sign *this* bill. Of course, if he thinks amendments are in order, it is his privilege to request the legislature to pass an act, incorporating such amendments. Certainly nobody would presume to deny his right and authority to do that, but we do not yet perceive why it is necessary to postpone his signature until the last moment the law allows, and why the Act should not be made effective at once. Of course, the Governor's right to request amendments would remain inviolate.

We know of no rule of legislative procedure, however, which would permit the amendment of this particular act before it becomes law. It is no longer a bill in the process of consideration in either House. It became an act upon concurrence by the Senate with the House amendments, and ratification by the Speaker and the President pro tem of the Senate on May 5, 1945. The legislature has done its duty. Its deliberations have resulted in, and have transformed the Bill into, an Act. The Act becomes effective with the Governor's signature, and that it has not yet received. As the matter now stands, it may become law in either of two ways—by the signature of the Governor or by his failure to act with respect to the measure within three days after the legislature convenes for

its next session. If the Governor had vetoed the measure it might still have become law by vote of two-thirds majority in each House. There is no provision for recommitting the act with demand for amendments, and without having one of the three results just mentioned. Apparently, therefore, in view of the Governor's unequivocal statement that he will sign the bill, the fact that if he does not sign it within three days after the legislature convenes it will become law without his signature, and the further fact that amendment within that length of time by separate act is a practical impossibility, it seems now fairly certain that the present act will become law shortly after the first of January.

We are indeed glad that the Governor has finally decided to sign the measure. This action will meet with general approval by members of the legislature, the State Hospital Association, the members of the South Carolina Medical Association, and other organizations and individuals throughout the state who sincerely have the interest of the mass of the people at heart. It is gratifying to know that South Carolina apparently will, at long last, be removed from the small and ever decreasing minority of states (she is among the five left) in which no Blue Cross operates. We think it is a pity, however, that the Governor felt the necessity to postpone his action for a period of eight months, and that the development of this progressive, humanitarian public service should have been retarded for that additional period of time, and the enjoyment of its advantages postponed accordingly.

HEALTH INSURANCE IN THE UNITED STATES

In a recent issue (July 21, 1945) of the Journal of the American Medical Association, there appeared a special article on the subject of Health Insurance prepared by Carl W. Strow, Research Consultant, and Gerhard Hirschfeld, Director of the Research Council for Economic Security. Mr. Hirschfeld has done extensive work in connection with economic features of the Social Security problem, and judging by some of his articles which have come to our attention, we would regard him as somewhat of an authority on the subject.

The article referred to is in the nature of an inquiry into the factors underlying the demand for a compulsory system of health insurance. It traces the history and development of the demand, and attempts to show the reasons and the forces which have contributed primarily to its great increase within the past few years. It goes further and undertakes to point out facts which, in the opinion of the authors, indicate a somewhat different actual situation with respect to the need or distribution of a system of compulsory insurance.

While we realize that the Journal of the American Medical Association reaches the offices of a large

percentage of our readers, in view of the importance of the subject, its timeliness in relation to our program and the developments in connection with medical economics, and recognizing also the fact that the average busy physician today has not time to consider fully all the publications to which he may have access, we risk the criticism of undue repetition in this effort to review some of the principal facts brought out in the article. We believe the facts developed are of sufficient importance to the profession and to the doctors as individuals, to bear repetition, in the event most of our readers have already read the original article.

According to Messrs. Strow and Hirschfeld, during the legislative sessions of 1945 more than 30 measures proposing cash sickness benefit plans or compulsory health insurance systems, were introduced in 12 state legislatures. Other bills called for studies of health insurance and in Congress a number of bills were introduced providing for some sort of medical care or sickness benefits. This year has been the most prolific thus far in the line of such proposed legislation.

After pointing out the fact that under any system of compulsory health insurance, medical and hospital care would be available to all those who desire it, with the costs being paid by the employers, employees, and possibly the government, attention is called to the fact that behind the current demand for such a system is the broad belief that present medical treatment is inadequate and that a definite economic barrier exists between the needs of and the medical services available to the average patient. This general proposition has been familiar to most of us for some time, but the article points out that the demand is far more accentuated in some sections of the country, strictly speaking, in some states, than in others. The authors make comparisons which tend to show that the greatest demand and the most active agitation for a change in this matter is to be found in states more densely populated and more highly industrialized; in short, those states in which facilities for complete medical care to all groups are most highly developed. In states like Mississippi, Georgia, the Carolinas, with their large rural populations, the *demand* has been comparatively slight, although there can be little doubt that among some groups the *need* is actually much greater. The conclusions to be drawn from these facts are that quite a large part, if not a majority, of the agitation stems from the activity of organized groups and results from the development of definite projects by organizations. The authors suggest the question whether sufficient is known about actual conditions underlying the national health problem at this time, and whether a decision should not be postponed until an opportunity is had for more research and study.

The article traces the history of the social reform movement in this country, recalling that it was supported by such individuals as Louis D. Brandeis, As-

sociate Justice and outstanding member of the Supreme Court of the United States, and a number of others less well-known, but doubtless as prominent in their particular fields. In 1910 the Russell Sage Foundation sent representatives to study European systems of social insurance, and as early as 1911 Brandeis advanced the idea of compulsory social insurance against sickness, at a meeting of a National Conference on Charities and Corrections. Other activities ensued and in 1915 a committee from the American Medical Association, acting with one from the American Association for Labor Legislation, drafted a Model Sickness Insurance Bill, called the "Standard Bill," which was introduced in several state legislatures. From 1915-1921, eleven legislative commissions were appointed to study and report on the proposal for state health insurance. Six of these reported favorably, and five unfavorably. In New York, the Standard Bill was passed by the Senate, but defeated in the House. By 1921 the movement lost its force and secured little attention for well over a decade.

In 1932 came the publication of the reports of the Committee on the Costs of Medical Care. Some of the facts developed by this Committee which probably contributed largely to the renewed interest in the subject, were these: On an average day 2% of the working population of the country were disabled by sickness, with an annual wage loss of \$1,000,000,000 in 1928 and 1929. The people of the United States suffer from one to two disabling illnesses per person each year. Female workers lose from 8 to 12 days, and male workers from 7 to 9 days per year. It was found also that the distribution of services was unequal, lacking in rural areas and unevenly distributed among individuals and classes. The 10.3% of the population suffering the largest amount of sickness paid 41.2% of the total cost of medical services.

Several subsequent surveys were made and the reports developed controversy as to the accuracy of the conclusions reached. According to the authors, the surveys have not held conclusive evidence of the size or definite knowledge of the nature of the national health problem.

The extent of private financial protection against the cost of health hazards is surprising. In 1944 the premium value of health and accident insurance had reached the astounding figure of \$525,000,000. Operating in 42 states, with a population of 110,000,000, 82 Blue Cross plans have outstanding 7,500,000 contracts covering 17,500,000 members. These represent more than 16% of the population in the states covered, and over 12% of the total population of the country. Hospitals with more than 90% of non-government beds are enrolled in Blue Cross.

Prepaid medical plans now protect between four and five million people, and in Washington, Oregon, California, and Michigan, where the plans are most highly developed, between 9% and 16% of the

populations are covered. The authors state, in the Journal article: "A widely organized system of pre-paid medical care would go far toward solving the medical part of our national health program."

Payments on account of sickness and disability were made by labor unions totaling \$50,000,000 between 1933 and 1944, and sickness benefit plans for fraternal societies cover more than 4,000,000 members. Taking these figures into consideration and also the coverage offered by life insurance, soldiers' insurance and numerous charity organizations, it is estimated that the face value of all private protection is close to the aggregate of the national wealth, or in excess of \$350,000,000,000.

Despite the foregoing, the authors recognize the fact that no disagreement exists between the advocates and opponents of compulsory insurance as to the need for better medical care. Disagreement is about the form, the administration and other details. Factors which are readily recognized by all, such as geographical location, occupational circumstances, and economic conditions, all contribute to the maldistribution of health services. Lack of sanitation and hygiene are referred to as major contributing factors to disease. (Incidentally, it occurs to us that a splendid opportunity is offered in the period immediately before us for correction of some of these conditions through expansion of sewer systems, improvement of water supplies, etc., as post-war projects, with the financial assistance which will be readily available.) Since the extent of the actual need in connection with a national health program is unknown, obviously the cost likewise cannot be stated. Despite this fact, advocates of health insurance have undertaken to make definite recommendations, and under the circumstances these can be little more than conjecture. They can hardly be termed estimates.

The part of labor in the problem is discussed and the general conclusion to be drawn from the facts stated is that the greatest demand for compulsory health insurance emanates from those states and communities wherein economic situation and labor conditions have resulted in the most highly organized groups and in which, by reason of close personal contact in living conditions and in occupations, there is the greatest opportunity for organized, concerted expression and action.

It has been impossible in the short space available in these columns to review the article completely. We have attempted to hit the high spots. It is hoped that nothing has been omitted which tends to break the continuity of thought developed by the authors,

or contort the facts presented. The piece is well thought out and discussed, and would be worth the reading in detail.

Messrs. Strow and Hirschfeld, on the basis of their research, express the following general conclusions:

The most powerful single force responsible for the origin of the demand for compulsory health insurance is organized labor.

The time most conducive for this demand is a period of depression.

The place most conducive for formulation and pressing of such demand is a large city.

Finally, the extent of the actual need has never yet been determined. A reliable and complete survey of the problem has never been made. The cost of an adequate system is an unknown quantity.

It appears that the intense agitation which finds its principal expression in the proposed legislation toward government control of medical practice and compulsory health insurance, whether state or national, is the result of the activity of highly organized and vocal minorities. The vast majority of the people have not expressed themselves, and their actual needs have not been determined. The unfortunate results which sometimes occur when organized minorities succeed in forcing their will upon the whole country are among the hazards which go along with the advantages of life under our democratic form of government.

NO ESCAPE

On the question of government sponsored medical care, too much emphasis has been placed on the doctors versus the government. In between are the people, and they are the ones who stand to gain or lose the most. As more than one doctor has pointed out, if state medicine is thrust upon the medical profession and the doctors don't like it, those who wish can escape by merely switching to some other line of business. But for the people, there is no escape. If state medicine is adopted and results in lowered medical standards there will be nothing the people can do about it—socialism is a one-way road. The people will be socialized, not the doctors.

The medical profession opposes state medicine because it has studied the lessons of history and knows that too much government in medicine will not bring adequate medical care to all the people.

(From the Weekly Bulletin of the St. Louis Medical Society, issue of May 25, 1945.)



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TEN POINT PROGRAM
of the
SOUTH CAROLINA MEDICAL ASSOCIATION

1. Cooperation

To promote closer cooperation and better understanding between all groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Political Control

To prevent political control or domination of medical practice or of medical education.

3. Study

To assemble and to amplify studies relative to the need and availability of medical care in each county of the state and in the state at large, and to publicize these findings.

To study all agencies in the state which are involved in the administration of medical care as to the type of work which they are doing and the effectiveness of the work which is being done.

To promote plans for providing or improving medical care where there is a need.

4. Care of Indigent

To prepare a uniform plan for the hospital care of the indigent, financed by public county funds, which may be used by individual counties or by groups of counties for their indigent sick, and to promote the general adoption of such a plan.

To promote the establishments of clinics in each county for the indigent ambulatory patients, financed by public county funds and operated or supervised by established hospitals or by the county medical society.

5. Hospital Insurance

To make voluntary hospital insurance available to all the people of the state and to promote the widespread purchase of such insurance.

6. Hospitals

To study the present availability and facilities of hospitals in the state and to promote the establishment of well-equipped and adequately-staffed hospitals in needy areas.

To establish through the State Medical Association standards for hospitals in South Carolina and to make public the names of those hospitals which meet these standards.

7. Group Health Insurance

To promote the establishment of group health insurance plans in all industries, large and small, in South Carolina.

8. Standards for Insurance

To establish standards for insurance companies selling hospital or group health insurance in South Carolina and to publish the names of those who meet these standards.

9. Medical and Nursing Education

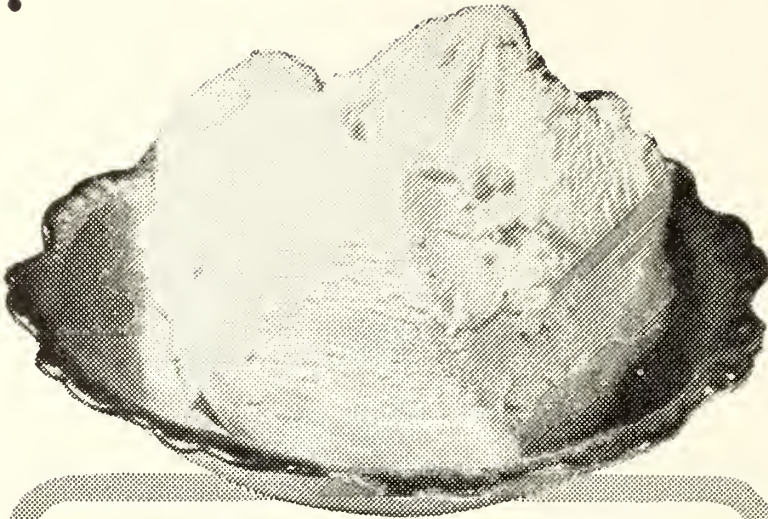
To promote the securing of adequate funds and facilities for the operation of the Medical College of the State of South Carolina.

To promote advancement in nursing education and nursing care in the state.

To promote the establishment of a loan fund whereby worthy young men and women of the state who are financially unable to meet the strain of a medical education may be able to secure aid.

10. Education of the Public

To acquaint the citizens of the state with regard to the agencies and facilities in the fields of medical care, public health, hospital and industrial insurance, and to encourage the people to use them on a much greater scale.



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PUBLIC HEALTH NEWS

EXECUTIVE COMMITTEE APPROVES RECOMMENDATIONS FOR WATER CONTROL LABORATORY

Recommendations of a special committee for a water control laboratory to be established in the Division of Laboratories of the State Board of Health have been approved in principle by the Executive Committee of the State Board of Health, and legislative authority for putting the plans into operation will be sought, Dr. Ben F. Wyman, State Health Officer has announced.

Under the existing system of water examination in South Carolina, the law requires that all public and quasi-public water supplies have chemical and bacteriological analyses made every three months at their own expense by a chemist and bacteriologist approved by the State Board of Health. The law further provides for a charge of \$5.00 each quarter for the examinations.

In compliance with this law, the State Board of Health appointed the late Dr. Francis L. Parker of Charleston State Chemist and for 30 odd years prior to his death a few weeks ago, Dr. Parker made all public water analyses for the State, and Dr. Wyman said that the Parker Laboratory has been authorized to continue making the water analyses until legislative approval of the water control laboratory is obtained and the laboratory is established.

The recommendations from the laboratory, which were presented to the Executive Committee at its meeting Wednesday, September 12th, by Dr. H. M. Smith, Chairman of a special committee appointed by the State Health Officer to make an intensive study of water examination in South Carolina, include the following points:

1. That a water control laboratory be established in the Division of Laboratories.
2. That the State Board of Health provide the analyses of public water supplies free of charge.
3. That water samples be collected by an employee of the State Board of Health and not by water plant operators.
4. That the bacteriological tests be made monthly instead of quarterly and that the chemical tests be made semi-annually or as often as deemed necessary by the Sanitary Engineers of the State Board of Health.
5. That certain specific chemical and bacteriological analyses should be made, and that facilities should be made available for the microscopical examination

of water supplies when needed.

6. That tests should be made on swimming pool water at regular intervals during the summer season, and that facilities should be made available for tests on sewage effluents and industrial wastes.

7. That an adequate staff of chemists, bacteriologists and technicians be provided for this work.

In making its recommendations, Dr. Smith's committee pointed out that "the present chemical and bacteriological tests on finished water are incomplete and do not comply with the Drinking Water Standards of the Public Health Service. The disadvantage of having the water specimens collected by municipal employees is obvious. The samples are usually collected at the water plant in many towns, whereas they should be taken from the distribution system. The location of the laboratory apart from the engineering control office is not for the best interest of the public's health."

Serving on the committee with Dr. Smith were Dr. G. E. McDaniel, Dr. Geo. H. Zerbst, D. F. Frick and J. W. Hammond.

VOLUNTARY BLOOD-TEST CAMPAIGN SUCCESSFUL IN RICHLAND AND LEXINGTON COUNTIES

Peak of 1000 Tests a Day Expected to be Reached

More than 5,000 tests have been made during the first 10 days of the six weeks blood-test campaign for the control of venereal disease in Richland and Lexington Counties which began September 4th, and approximately ten per cent of the tests have shown positive reactions, according to Dr. Joe M. Chisolm, Director of the Division of Venereal Disease Control.

Since the campaign began, approximately 200 cases of gonorrhea have been found and are being treated. Twenty-five doctors in the two counties are cooperating with the State Board of Health and the County Health Departments in the gonorrhea program.

Forty stations have been established at strategic centers throughout the counties and the response of the public is evidenced in the fact that in one station set up in the Wade Hampton Office Building for one day, blood specimens were collected from 181 employees in the building.

At the present time more than 500 blood specimens are being collected a day and a peak of 1,000 a day is expected to be reached within the next week, Dr. Chisolm said.

SECOND IN A SERIES OF CHALLENGES TO MEDICINE'S

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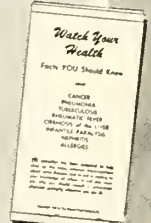
• **CANCER** killed 163,000 people in the United States during 1942, it is estimated*, and ranks second in causes of deaths. The rate apparently is increasing. About 300,000 new cases are diagnosed for the first time each year and approximately 475,000 persons are under treatment at any given time.

Many cancer patients can be cured by surgery, X-ray or radium if the disease is diagnosed early enough. There is not, however, sufficient information about the cause of cancer and its characteristics to have led to the discovery of a specific and generally applicable cure. Physicians are helping by reporting their experiences and observations. What will be the cure? Who will discover it?

People should be educated to the necessity of having examinations at the first symptoms indicative of cancer so that such curative measures as are available may be utilized as quickly as possible. Too many hide their condition until a cure is impossible.

To aid in such educational work, we have prepared a pamphlet — "Watch Your Health" — in which simple facts about this and six other serious diseases are given. Copies for distribution to your patients are available on request.

*U. S. Summary of Vital Statistics, 1942

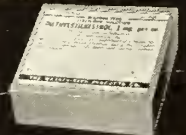


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PROJECTS RELATED TO HEALTH PLANNED FOR SOUTH CAROLINA TOTAL MORE THAN \$10,000,000

Nearly \$5,000,000 Already Approved by Planning Board

Applications for projects directly related to public health and totaling more than \$10,000,000 have been filed with the South Carolina Research, Planning and Development Board, it was announced today by H. M. McElveen, Administrative Assistant to Dr. Ben F. Wyman, State Health Officer.

Already, Mr. McElveen said, projects totaling \$4,699,700 have been approved by the Planning Board and are now in Washington carrying a project number. Most of the remaining applications have been approved in Columbia and forwarded to Atlanta for approval there before being sent to Washington.

The projects include waterworks, sewage systems, health centers and clinics and hospitals.

Projects now in Washington for final approval are listed below by counties.

Allendale — Fairfax waterworks \$46,500; Fairfax sewage collection system \$77,500.

Charleston—Charleston tuberculosis hospital \$750,000; North Charleston Sewer Facilities \$216,500; Charleston Health Center \$230,000; S. C. Medical College clinic hospital \$3,000,000.

Clarendon—Manning waterworks \$18,220; Manning sewer \$84,400.

Edgefield—Edgefield waterworks \$156,920.

Saluda—Ridge Springs sewerage system \$56,500; Ridge Springs waterworks \$63,160.

Other counties that have filed similar applications with the Planning Board but whose applications have not yet been sent to Washington are: Anderson, Beaufort, Berkeley, Calhoun, Cherokee, Chester, Colleton, Dorchester, Fairfield, Florence, Greenville, Greenwood, Horry, Lexington, Marlboro, Oconee, Orangeburg, Richland, Spartanburg, and Union.

All counties, Mr. McElveen said, that have not filed applications and are planning to do so should have them completed at once and sent to R. M. Cooper, Director of the South Carolina Research, Planning and Development Board, Wade Hampton Office Building, Columbia, S. C.

Proper application blanks, known as Form 3 Application for Advance Planning for Non-Federal Public Works may be obtained upon request to the

Federal Works Agency, attention of Mr. Geo. S. McKivven, Senior Engineer, Bureau of Community Facilities, 1745 Sumter Street, Columbia, S. C.

ITEMS OF INTEREST FROM THE MINUTES OF THE EXECUTIVE COMMITTEE MEETING WEDNESDAY, SEPTEMBER 12TH

Committees: Dr. W. R. Wallace, Chairman of the Executive Committee of the State Board of Health, appointed the following committees:

Sanatorium—Dr. Geo. W. Dick of Sumter, Chairman; Dr. D. Lescsne Smith of Spartanburg; Dr. Vivian F. Platt of Conway; Dr. W. R. Mead of Florence; Dr. W. R. Wallace of Chester.

Administration: Budgets and Accounting — E. C. Rhodes of Columbia, Chairman; Dr. Vivian F. Platt and Dr. W. R. Wallace.

Local Health Service and Laboratories — Dr. W. L. Pressley of Due West.

Maternal and Child Health and Public Health Education — Dr. Joseph I. Waring of Charleston.

Venereal Disease — Dr. D. Lescsne Smith.

Crippled Children — Dr. W. R. Mead.

Preventable Diseases and Vital Statistics — Dr. L. D. Boone of Aiken.

Cancer Control and Industrial Hygiene — Dr. R. B. Durham of Columbia.

Dental Hygiene — Dr. Geo. W. Dick.

Drugs and Biologicals — Dr. Vivian F. Platt.

Crippled Children: The Executive Committee, at the request of the Advisory Committee of the Crippled Children's Program, prescribed that in cases of acute anterior poliomyelitis admitted for hospitalization under the Crippled Children's Program, the pediatrician or internist be placed in direct control of the cases and that orthopedic consultation be requested and arranged for at the earliest possible moment. The Executive Committee also prescribed that after a suitable period in the progress of a case, the orthopedist assume full direction and control if any resulting paralysis or orthopedic disability of the patient occurs.

Penicillin: The Executive Committee approved the use of penicillin, 5 per cent sulfathiazole solution, or 1 per cent silver nitrate solution as suitable media for use in the eyes of newborns to prevent ophthalmia neonatorum.

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Literature and Sample on Request

BUY VICTORY BONDS

ALLERGY GROUP TO MEET IN CHARLESTON

During the past 18 months there has been some discussion of the possibility of an organization for those interested in allergy in the southeast. This discussion has not led to any definite plans because of war conditions. Now that hostilities have ceased and travel restrictions lifted, it appears that this discussion can be continued.

The Graduate Seminar of the Alumnae Association of the Medical College of South Carolina has invited any and all persons interested in such an organization to meet with them in Charleston, S. C. at the time of the Seminar on October 31st, November 1st and 2nd. They will make whatever arrangements are desired for this group and have invited a member of this group to be guest speaker on the general program. Dr. Hal McCheney Davison of Atlanta, Ga. has been invited to be guest speaker.

It was decided by those interested in this organization to accept this invitation to meet and selected Thursday, November 1st, as the day for the meeting of those interested in Allergy. The morning will be given to discussion of organization, a Dutch luncheon followed by round table discussion in the afternoon with Founder's Day Banquet at night.

It is hoped that everyone interested in allergy will make an effort to attend the meeting. It is not to be limited in membership to those who are doing allergy, but to all doctors who desire to participate—the internist, the general practitioner, the dermatologist, the pediatrician, the otolaryngologist and any other who wishes to become affiliated.

All hotel reservations will be handled by Dr. Horace Smithy, Medical College, 16 Locust Street, Charleston 16, S. C. Please make your reservation early.

Luncheon reservations are being taken by Dr. Katharine Baylis MacInnis, 1515 Bull Street, Columbia 49, S. C.

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THE VICTORY MEETING of the

Southern Medical Association will be held under the sponsorship of the Campbell-Kenton County Medical Society of Kentucky in Cincinnati, Ohio, November 12-15. It is a Kentucky meeting. The Southern Medical Association meetings always have been and always will be the essential meetings IN and FOR the South. The Southern as an essential medical organization has carried on without a break during the war—it has not missed a meeting. Now it will celebrate the victory with a great VICTORY MEETING. In its twenty-one sections, two general sessions, six conjoint meetings, and the scientific and technical exhibits, in a streamlined program, one will get the last word in modern, practical, scientific medicine and surgery.

REGARDLESS of what any physician may be interested in, regardless of how general or how limited his interest, there will be at Cincinnati a program to challenge that interest and make it worth-while for him to attend.

ALL MEMBERS of State and County medical societies in the South are cordially invited to attend. And all members of state and county medical societies in the South should be and can be members of the Southern Medical Association. The annual dues of \$4.00 include the Southern Medical Journal, a journal valuable to physicians of the South, one that each should have on his reading table.

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**Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154; *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60; *Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241; *N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592.



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NEWS ITEMS

Dr. M. J. Boggs, who has been Health Officer for McCormick and Greenwood Counties with headquarters at Greenwood, has been appointed Health Officer for Abbeville County. He will make his home at Due West. He will be associated with Dr. W. L. Pressly.

Dr. J. E. Lipscomb has been discharged from the armed forces and will resume his practice in Greenville soon.

Major C. T. Larisey, Army Medical Corps, has returned to Hampton after two years and eight months of service in the European theatre of war.

Major J. W. Fouché has been discharged from the Army and plans to open his offices in Columbia.

Colonel H. G. Waddell has accepted the position of resident physician at the University of South Carolina.

Dr. C. H. Fair has opened his offices for the practice of medicine in Greenville. He was recently discharged from the Army.

Dr. Wes Simmons has returned to Greenville from service in the armed forces. He will limit his practice to anaesthesia.

BOOK REVIEWS

TREATMENT IN GENERAL PRACTICE

5th Edition, Harry Beckman, W. B. Saunders Co., Philadelphia.

This is the fifth edition of a book which first appeared in 1930. To those who are acquainted with the work we need say little except to inform them that the book has been brought up to date with discussions of such newer conditions as Acute Infectious Lymphocytosis, Atypical or Virus Pneumonia, Airlsickness, Blast Syndrome, Cardiogenic Shock, Human Serum Jaundice, Rh Factor Syndromes, Subclassical Deficiency States, etc.

To those who are not acquainted with this book, we recommend it highly. Particularly would we recommend it to that physician who is leaving medical service with the armed forces to go into civilian practice. We believe that this physician will find no book more valuable as a text for study and as a volume for reference. Dr. Beckman has done a fine job and is to be commended highly.

BACILLARY DYSENTERY COLITIS AND ENTERITIS

Joseph Felsen, New York. W. B. Saunders Co., Philadelphia.

"Dr. Felsen has devoted many years to the study and control of Shigella infections. He has dealt with epidemics and has followed cases into their late manifestations. He has produced a motion picture which is widely used for educational purposes. He has established the 'International Dysentery Registry' as a means of promoting coordinated study and preventive activity. He now presents the first comprehensive monograph on the subject to be published in the United States. It records his own studies and points of view as well as the work of other authorities, and makes available for the first time the correlated investigations of the pathologist and the clinician in bacillary dysentery, enteritis, and colitis. This work should not only contribute significantly to better diagnosis, treatment, and prevention, but should also provoke discussion and research which will settle some of the unsolved problems of Shigella infections."

From the Foreword by Dr. Henry E. Meleney.

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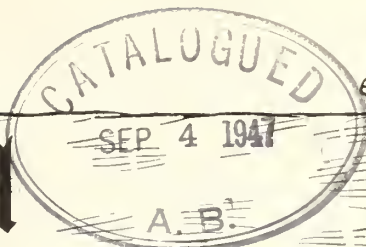
South Carolina Medical Association

1945-1946

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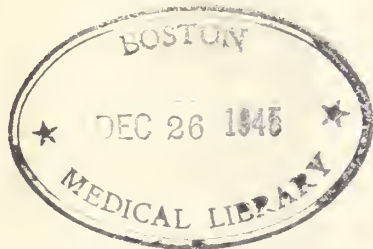
The Journal of the South Carolina Medical Association

NOVEMBER, 1945

VOL. XLI, NO. 11

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Minutes of Ninety-Seventh Annual Session House of Delegates, South
Carolina Medical Association, October 2, 1945, Columbia, S. C. 275-307



Editorials

BACKGROUND

Three Decades of Clinical Experience

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VOLUME XLI

November, 1945

NUMBER 11

Ninety-Seventh Annual Session House of Delegates South Carolina Medical Association

OCTOBER 2, 1945, 2:30 P. M.
Hotel Columbia — Columbia, S. C.

Dr. W. T. Brockman: The meeting will please come to order. We will ask for a report of the Credentials Committee.

Dr. Smith: Would it be in order now to say Spartanburg has no credentials, they haven't come down, the president was to come down with the credentials. There are no representatives here, officially. I would like to move Dr. Dennis Hill and Dr. Lesesne Smith, Jr., be seated as delegates.

The Chair: What is the pleasure of the house? (The motion of Dr. Smith was seconded.)

It is moved and seconded the Spartanburg delegates be voted in.

The Chair will rule, Dr. Smith, that we will take up your motion in a minute, when we finish hearing the report of the Credentials Committee.

Dr. J. C. Sease: Mr. President, there are sixty-seven (67) delegates registered.

The Chair: The question now before the House is shall we seat these two men from Spartanburg, who are the elected delegates. They are both appointed by the president and he was to bring their credentials when he came and he didn't come.

Motion from the floor: I move they be seated if they were elected delegates. Motion seconded.

The Chair: It has been moved and seconded that the two delegates from Spartanburg, Dr. Lesesne Smith, Jr., and Dr. Dennis Hill, be seated. You have heard the motion, is there any discussion? (The question was put, the motion was carried) It is so ordered.

The Chair: At this stage, it is a pleasure to me to

finish up a little of the ragged edge of these wartime dealings that we have had to carry along with, and turn the meeting back so that we can technically, at least, live up to our by-laws and Constitution, and I really enjoy turning this back at this time to our President, who is winding up his term, Dr. Wallace.

(Applause)

Dr. W. R. Wallace: Mr. President, and gentlemen, this is indeed a very gracious courtesy the President and Secretary have accorded me. Really, my term of office, according to all rules and regulations should have ended last April and at that time the Council at its meeting, in lieu of the regular House of Delegates, agreed that it would be the best policy for our President-Elect to take over. There are many reasons for this. At that time we did not know when we would be able to have a meeting of our House of Delegates; it would have been very unfair to our President-Elect to allow him to serve probably only two or three months. The main point was that the responsibility of the program for next year, our scientific program is entirely on his shoulders. My program was cancelled, and all my guest speakers were released from their promise to be with us, and we thought it best for the President-Elect to take over so that he could appoint his committees and arrange his program.

I notice on the printed program here that there is to be an address by the retiring president. I think an address by me, at this time, would be very much out of time and out of place, because the glory of this year is all President Brockman's, and the responsibility also.

Of course, there are always problems before the medical profession, and what few remarks I shall

make are not those of a retiring president but of a private member of the Medical Association of South Carolina. The fact that we have problems is the thing that makes medicine so intensely interesting. Without problems it would certainly be a very drab profession. We have our problems in the practice of medicine, and also in medical organizations, and so the solving of these problems always furnishes us with plenty of food for thought and plenty of things to occupy our attention.

One of the problems that is immediately before us is the return of our medical colleagues who have been in the armed services. And right now I would like to say that we extend to everyone of them, individually, our very heartiest welcome. We revere and honor them, for what they have done because no where in the history of medicine has the job been done so well as has been done by the medical corps of the army and navy.

I would like to pay tribute to our Council, for its work during the war. The members have carried on nobly and I am sure the affairs of the Medical Association have been very safe in their hands, and our business has been handled with the greatest dispatch and efficiency. During this period, when the House of Delegates was not allowed to meet, Council has seen that everything has been well taken care of.

To say these returning colleagues are "welcome" is putting it mildly. We revere and honor them for what they have done and, of course, we welcome them back in our midst to help take up and carry on the civilian duties. For those of us who have been here at home, the doctor shortage has been acute and it probably will be for some time to come. So, as our veterans return we want to give them not only our encouragement but advice as to the best places in which to locate, if they care to change from their original location; and also those younger men who did not have a chance to engage in practice, but who went into the armed forces from the medical colleges and hospitals, we want to give them advice and also want to give them an opportunity and make it possible for them to continue their medical education and residences and internships, wherever it is desired. There are those who want to take up the specialties. There is also a shortage here, though not quite as acute as in the general practice of medicine. We want also to give them the information about those places in the State where the specialties are short.

When we begin to talk of doctor shortage we naturally lead up to medical education, which has been a problem in South Carolina, and which has been handled well and which we believe is on the eve of great expansion. Our College has carried on nobly in its more than 100 years of service and we trust will carry on in even larger measure in the years to come. Each one of us must individually and collectively stand behind our college and see that it

gets the financial support that is necessary for maintenance and expansion, which our Dean figures is so much needed at this time.

Just how long we shall stay away from socialized medicine, which gives us a little shudder when we hear the word, depends, in my opinion, on just how well the medical profession, in its different branches cooperate and coordinate the general practice of medicine, the specialties, and the Public Health Service. We want in South Carolina a healthy citizenship, and to that end we must always foster and encourage public health measures that render preventable diseases less, so we will have a stronger and better and healthier clientele with which to practice medicine and carry forward the citizenry of South Carolina.

Of course, socialized medicine gives us a little shudder and yet, we must admit that a certain amount of socialized medicine has been with us for a certain length of time and it has been increasing and will increase, in years to come. It has so often been said that socialized medicine began over 100 years ago when the State took over the responsibility of insane patients, and later on took over the care of tuberculous patients. During this period of war some changes have been brought about. We will all have to admit that the program for the care of our soldiers' wives was not such a bad proposition. Had it not been for this item of socialized medicine, the burden of caring for soldiers' wives would have been very heavy on the professional men in this state. Records show that a good job has been done and that the mortality rate under this program compares well with the practice of obstetrics in our State, particularly, and all over the United States. Of course, we are not yet prepared, nor do I think we should ever be willing to go all-out for the obstetrical care of patients, such as has already been advocated by Senator Pepper in his bill, in which obstetrical care is to be rendered to all people. But the part that has been carried on in this State, in the care of soldiers' wives and their dependents, I think, has been very good and has rendered a great deal in keeping up the morale of those soldiers away from home who were worried and uneasy about the welfare of their wives and children.

The atomic bomb, discovered at such a tremendous amount of expense and through intensive scientific investigation, startled the world and the discovery of the atomic bomb saved, we know, thousands of lives of our soldiers. No criticism will ever be heard from anyone as to the amount of money and the amount of time that was put on this particular project. But the thought occurs that if we could have the same amount of intensive effort, the same effort from an equal group of scientists, and an equal amount of money, many diseases might give up some of their dreaded potentialities. So, it is the duty of all of us to encourage investigation

and research so that these maladies will not continue to take the heavy toll of human life that they have in the past.

With these few remarks, as a private practitioner of your state, I will call the next part of our program. (Applause)

Dr. Wallace Presiding:

We will have a slight change in the program, as it is outlined and will call for the **Report** of Mr. Jack Meadors on the **Ten Point Program**. Mr. Meadors.

To the Council and House of Delegates of the South Carolina Medical Association:

At the direction of Council, the Ten Point Program was instituted on September 1, 1944. A report of activities to that time was submitted at the annual meeting of Council in April, 1945. The present report covers the full year's operation and includes, in less detail, the substance of the April report.

The offices already held by the South Carolina Medical Association in Florence provide ample space and accommodations for work under the program. A new desk and one filing cabinet were all the additional furniture needed. An efficient office secretary is employed and supplies all of the necessary clerical assistance.

The library of publications of the State and other Medical Associations, including the Journal of the American Medical Association and reports of Government departments concerned with medical care, is practically complete. With the assistance of the office secretary, we attempt to keep closely in touch with the articles in these magazines dealing with the economic phases of medical practice. The more important ones are given special attention, and extracts from many of them will be found from month to month in the columns of this department in the Journal.

I—Cooperation

Among our first official acts after taking over the work of the program was the direction of letters to the State Health Department, the County Health Officer in each county of the State, the Executive Secretary of the South Carolina Tuberculosis Association, the Chairman of the South Carolina Industrial Commission, the State Superintendent of Education, the State Insurance Commission, and others in similar official positions within the structure of the State Government and otherwise, advising them of the aims and purposes of the Association, enclosing a copy of the printed program, and requesting their cooperation and suggestions with respect to carrying out the various phases of the work.

In connection with this phase of the program, the important feature is not so much in any definite re-

sults accomplished upon our own initiative, but rather the fact that under present arrangement, the State Association has the mechanism for and is in readiness to cooperate from time to time as the occasion may arise, in various matters concerned with the improvement of medical care throughout the state.

II—Political Control

We have endeavored to keep fully informed on the effort in Congress and elsewhere to increase the measure of control by politicians and governmental agencies over the practice of medicine. For several months following the institution of the program, proponents of the Wagner-Murray-Dingell Bill were rather inactive, and prepared for their next move. True to expectations, shortly after the new Congress convened in January, Senator Murray reintroduced the original bill, but made no active effort to secure consideration.

During last year the sub-committee on War Time Health and Education, headed by Senator Pepper, of the Senate Committee on Education and Labor, held a number of hearings, took testimony from witnesses covering a wide variety of professional and lay opinion, Government and otherwise, and in February the committee published its first interim report. No definite legislation was proposed by the committee, however.

Then on May 26 there was introduced simultaneously in both Houses of the National Congress, the 1945 version of the Wagner-Murray-Dingell Bill, under the designation "Social Security Amendments of 1945." The bill was introduced by the same sponsors who had fathered the measure in 1943, Senators Wagner and Murray and Mr. Dingle in the House of Representatives.

In the July issue of the Journal we attempted a synopsis of the provisions of Section 9, which is that part of the bill pertaining to compulsory health insurance, and reprints of this analysis have been made and are available in our office in case any of the members of the Association wish to consider it further.

A similar analysis of the recently introduced bill providing for Maternal and Child Welfare services was printed in the September issue of the Journal. Reprints of this also will be available.

It was our purpose in both the attempts referred to above, to make available to the members of the profession and any others who might be interested, reasonably concise, factual statements of the contents of the respective bills. They were written with a minimum of comment or expression of personal opinion, and in the effort to rearrange the content of the legislative proposals in such a manner that they would be accessible to the casual reader without the necessity of groping through the mass of legalistic verbiage

which is perhaps necessary, but certainly confusing. We plan to continue our efforts along this line and in the months to come will attempt to present from time to time similar surveys of other proposed legislation in Congress or perhaps in certain of the states which, if adopted, would have drastic effects upon the control and practice of the medical profession.

III—Study

The nature of our efforts along this line will be clear from the foregoing and from the remainder of this report without the necessity of special comment on the subject here.

IV—Care of the Indigent

Very soon after the program was instituted letters were addressed to the State Senator, as head of the legislative delegation, in each county in the state requesting information on the method of dealing with medical care of the indigent in the different counties. From the 46 contacted, 31 replies were received. A number of these were full and furnished valuable information. Others were limited. It is hoped that on the basis of information received and through negotiation with and the cooperation of lawmakers throughout the state, some general statewide program on this important phase of medical care may be worked out. Effort is being continued in this direction.

V—Hospital Insurance

Any member of the Association who read the pages devoted to this department in the Journal during the first 4 or 5 months of the year, is aware of the effort made and the time expended in connection with the introduction and passage through the legislature of the enabling act for Blue Cross organizations in South Carolina. Numerous trips were made to Columbia and much time spent in the State House during the legislative session.

The matter was covered in detail from month to month and repetition here of anything more than the general results is unnecessary. After adoption by the Senate, the bill went to the House, where all the dilatory tactics known to legislative procedure were employed, but the measure was finally passed with a number of amendments. When it was returned to the Senate in the closing days of the session, a final effort was made by the determined opposition to pigeon-hole the measure by referring it to a free conference, but on the last day of the session, May 5, the House amendments were concurred in by the Senate and the Act ratified and sent to the Governor. There it remains. We have been in conversation, direct and by telephone, and in correspondence, with the Governor on a number of occasions in the effort to obtain his approval of the act. In July, a representative group consisting of Dr. Julian Price, your program director, and some of the more active members of the proposed Blue Cross organization,

conferred with Governor Williams for an hour and a half on the matter. The act has not yet been signed, but within the past few weeks the Governor has written letters to 3 or 4 individuals and has given a statement to the press that he will sign the act upon the opening of the 1946 session of the legislature. At the same time, he states, he will propose certain amendments. Approval or rejection of the act in its present form however must occur within the first three legislative days and cannot await action upon any proposed amendments. From the Governor's most recent statements it now appears that the act will become law early in January, and setting up a Blue Cross organization in South Carolina can then go forward.

VI—Hospitals

The recently introduced Wagner-Murray-Dingle bill, or "Social Security Amendments of 1945," contains one section devoted to provisions for nationwide surveys of the needs for hospital facilities, followed by a 10-year program for the construction and expansion of hospitals. In January of this year, the Hill-Burton Bill was introduced for the same purpose and with similar provisions. The latter is looked upon with favor by the American Hospital Association and, in principle, by the AMA. During 1944 plans of the National Commission on Hospital Care were perfected for promoting and assisting with similar surveys in each state. Both the Hill-Burton bill and the section of the Social Security Amendments of 1945, provide for the making of such surveys by a state agency, to be designated, and in the early part of the present year we attempted to cooperate with others similarly interested, in the effort to secure the appointment by the Governor of a representative commission consisting of responsible and prominent individuals to take charge of the work in South Carolina. About this time, however, a bill was introduced in the legislature providing for the making of such a survey by the State Health Department and efforts in connection with the proposed commission were discontinued. The bill referred to failed to pass and at present no agency is designated for the purpose in this state.

From information now available, it appears that the state commission on Research, Planning and Development, created and provided for at the last legislative session, provides an ideal set-up for making this survey. We do not know at the present time whether it will be possible to interest the members of that commission and the other officials concerned in the subject, but if that could be done, it is our belief that the matter would be more adequately provided for and would result in a more careful and accurate type of survey than would otherwise be obtained.

VII—Group Health Insurance

With the exception of obtaining information from the State Insurance Commission and the South Caro-

lina Industrial Commission relative to the type and extent of group health insurance plans now in effect, and discussion with the heads of certain representative industries in the state relative to group plans operating in their organizations, no action has been taken with respect to this subject.

VIII—Standards for Insurance

No effort has been made to institute any action along this line.

IX—Medical and Nursing Education

In view of the recently instituted program for the expansion of the Medical College of South Carolina under the direction of the Board of Trustees, no independent action on our part was deemed advisable in connection with this phase of the program thus far. Needless to say, we stand ready to enter actively, promptly, and with enthusiasm into any phase of the development of whatever expansion program the House of Delegates may adopt.

X—Education of the Public

A number of opportunities have been presented for explaining the Ten Point Program, the Blue Cross Plan and other subjects related to the effort being made by this Association, to various groups throughout the state. We have taken advantage of every such opportunity, having talked to seven service clubs, two state organizations, the Spartanburg County Health Council and on four radio programs. Talks have been made at district meetings of the Medical Association in all the districts with the exception of one. From our efforts in this connection, we have had two reactions: First, that a great deal of work remains yet to be done among the doctors themselves in order to convince them of the necessity for an active, militant program by the profession if it intends to salvage a substantial part of what we might call the old way of life. Second, that the public is fairly well informed as to what we are trying to do, but is perhaps not yet fully convinced of its purpose and effect. There is a definite impression in the minds of many people that the medical profession needs some control and direction, and the rosy prospects pictured by the economic planners seem to offer the average citizen a great deal for nothing. Many apparently have not stopped to think of what they must sacrifice, not only in the form of increased taxes, but in those things that are intangible but even more important than money, in order to obtain the very doubtful advantage of government controlled medical care. There remains a great deal more work to be done in the education and enlightenment of the public in this regard. The facilities and service available, already, and under an expanded system of voluntary, non-profit prepayment for medical and hospital care are not yet fully realized by either the profession or the public at large. The work is progressing, but a great deal must be done to overcome

the headstart already obtained by the advocates of compulsory methods.

So much for the efforts with which we have been occupied during the past 12 months. Now let us look briefly at the activities which will demand our attention in the future. There are a number of these, and they are all vitally important.

(1) With the termination of the war and the vast increase in the number of discharges of medical officers, this association faces an opportunity for genuine assistance in two respects: first, to all the members who have left their practice or have been prevented from taking up practice to serve their country in time of war, and, second, to communities within South Carolina which are without adequate medical attention.

Most of the state medical societies are giving attention to this subject and already inquiries are reaching the office of the secretary both as to possible locations for the returning physicians and from communities which are in need of general practitioners and specialists. The admirable work done by Dr. W. L. Pressley in the Procurement and Assignment Services will be continued for the time being. It appears that some structure should be set up within the Association to cooperate with Dr. Pressley in any way in which he might feel the need of assistance and to take over the burden of the work under his valuable advice and counsel when and if the Procurement and Assignment Service operated by the Federal Government is terminated. With the facilities at hand in our office we believe that valuable service could be rendered in this connection, and it will be a service which would be entered upon with the utmost enthusiasm since we would feel that we were actually doing something worthwhile for the individual returning medical officer and at the same time carrying out the program adopted by the Association in attempting to assist in a more satisfactory distribution of the facilities for medical care.

(2) Within the past few months it appears that the activities of practitioners of Naturopathy and related sciences, so-called, have increased. Our attention has been called on several occasions to the practices of certain individuals who are taking advantage of the more gullible and unfortunate members of the public and rendering services the value of which is highly questionable, in return for fees exceeding by many times a proper charge for the treatment of the same conditions, by licensed doctors of medicine.

We have made some study of the statutes of this state with respect to Naturopathy and Chiropractic. Without attempting to express final conclusions at the present time, we have read enough to be convinced of the fact that the practice of Naturopathy in South Carolina, the qualifications for its practitioners and the standards required, would bear thorough investigation. We are also of the belief that it may be possible to take steps to remedy the existing situation,

in view of the language of the statute on the subject. Having received several inquiries and having had the matter called to our attention by various individuals in different parts of the state, it will be our intention to make further study of this subject and perhaps to make certain definite recommendations to the Council in regard to it, within the very near future.

(3) Of course our efforts in connection with the proposed Blue Cross Plan and its enabling legislation will be continued. As pointed out above, the act has not yet been signed. We will attempt to keep in touch with the situation and will be on hand when the legislature convenes in January to observe at first hand any developments in connection with the matter and to take, or recommend, such steps as may appear to be advisable at that time. South Carolina is now among the five remaining states in which Blue Cross is not yet authorized. In view of the accounts appearing in almost every publication which has anything to do with the matter of furnishing medical or hospital care, we are still as firmly convinced as in the beginning that the provision for and authorization of the Blue Cross Plan in South Carolina is the first fundamental step in the development of our program, the *sine qua non* for the accomplishment or for any substantial progress toward realizing our objectives. It is our belief that the South Carolina Medical Association should continue to cooperate as it has done in the past with the South Carolina Hospital Association in connection with this movement and in various other activities. In this period when the medical profession is under fire, its method of practice being attacked by powerful pressure groups, and when there is danger of changes which we conscientiously believe, and are certain that we know, will be to the vast disadvantage of the public as well as the profession, we can think of no good reason why there should not be sincere community of interest, cooperation and mutual understanding between the doctors and those in charge of management and administration of our hospitals wherein such a large part of the doctors' work is done.

(4) The development of plans for pre-payment of medical services is proceeding at a rapid rate. According to recent estimates plans are now in existence or are being provided for in ----- states. The movement appears to be growing by leaps and bounds. The principle evidently is receiving more sympathetic consideration by those elements of the medical profession which heretofore have been ultra-conservative with respect to this method of dealing with the problem. The Journal of the AMA carries regularly a department with news on the development of medical prepayment plans. Various types of plans are being set up, some on the indemnity and some on the service basis, and all of these which are voluntary carefully preserve the patient-physician relationship and freedom of action by the patient with respect to choice of his physician, and by the physician in reference to fees charged patients whose

incomes are above certain minimum brackets.

It is our feeling that the same developments should proceed in South Carolina, that there is no good reason why a principle of prepaid medical care, if satisfactory to physicians in other states, would not be satisfactory to physicians in this state, and that if such plan tends toward removing any substantial portion of the cause for current complaint and agitation for Federal Control, then South Carolina, with its pioneer program, should keep pace with her sister states in development along this line. We believe that the Blue Cross organization should proceed first, and advantage should be taken of the experience gained in connection therewith in the developing of any medical prepayment plan. We propose to make further study as to this, with a view to recommendations in the future.

(5) It is highly important that the subject of means for a comprehensive state-wide hospital survey be kept alive and that the Medical Association and its members take an active part in connection with the matter. The welfare of the general public, of course, is the prime consideration. After that, the physicians as a group have more at stake in the development of the post-war hospital program than any other group. It is our purpose to keep closely in touch with this subject and, with the approval of this body, to make recommendations with respect to the most feasible and satisfactory plan for procuring the survey.

(6) Finally, there is no indication of any let-up in the flood of proposed legislation affecting, directly or indirectly, the medical profession. To the extent of our ability and the limit of time available for the purpose, we shall keep ourselves informed with respect to these bills, and the contents of those which appear to be most important and most likely of passage will be presented to the members of the Association for their study and attention through the pages of the Journal or otherwise. If there was ever a time when there was a need for this type of service to the medical profession, that time is now.

In the publications of the various medical societies which come to our desk from all over the United States, there is constantly increasing emphasis upon the value of good public relations and the importance of their further development. The subject has been badly neglected in some quarters. Too much has been taken for granted. It is the natural tendency of a sincere, conscientious individual, to assume that the world will take him as he is, that his sincerity and the earnestness of his effort will be recognized and rewarded by the confidence of the public and by the success of his achievement. That is the professional ideal in medicine, law and other fields. That is the basis for the ethical standard which does not permit advertisement of one's skill and services in the professions. But apparently the time has come when the public cannot be depended upon to recognize and understand the idealism of the doctor's professional

attitude. Under the influence of pressure groups with selfish interests to serve, the public is being lured away from its confidence, and from its belief in the sincerity of purpose of the medical profession. That is the reason why a conscious, active effort on the part of the profession itself is necessary to retain the priceless heritage which its idealism and its conduct in the past have earned for it. The public must be kept correctly informed and must remain convinced that the physicians realize that their interest and welfare are identical with the best interest and welfare of the public which they serve. Through all of our activities, this basic principle has been and will be kept in mind, and our efforts governed accordingly. September 15, 1945.

Respectfully submitted,
M. L. Meadors

The Chair: Mr. Meadors, we thank you for that excellent report which summarizes a year of splendid service. One of the forward steps of our Association was taken in the election of a public relations man, in our organization. We were particularly fortunate in the selection of the person who has served so efficiently in that respect for the past year.

We will now have the report of the Secretary.

REPORT OF THE SECRETARY

Members of the House of Delegates:

Your Secretary made his annual report to Council at its meeting on April 17, 1945, and this was printed in the May, 1945 issue of the Journal. It hardly seems necessary to read that report at this time so your Secretary will summarize what was presented and make certain observations and suggestions.

Membership

Our membership now stands at 926.

Finances

The financial condition of the Association is sound. Sufficient funds are on hand to carry on the activities of the Association and of the Ten Point Program up to January 1, 1946. Additional funds must be secured, however, if work under the Ten Point Program is to continue after that date.

Two policies have been adopted regarding annual dues and your Secretary, at the suggestion of Council requests that this House of Delegates endorse these policies so as to avoid any misunderstandings.

(1) All members of the Association whose dues were paid in full when they entered military service have been carried on the books as members. When these physicians are discharged from service and return to South Carolina they continue to be members of the Association but they are not liable for payment of dues until the first of January following their discharge.

(2) Whenever a physician becomes a member of the Association he is liable for the payment of the regular annual dues regardless of the time of year at which he becomes a member.

The Journal

The Journal has been published each month and strenuous effort has been made to make its pages informative, interesting, and readable. Revenue from advertising in the Journal is at an all time high. Your Secretary would beg each member to bear this in mind and to patronize our advertisers who are responsible for this condition.

Our Colleagues in the Service

While the war lasted, our chief concern lay in supplying the armed forces with a sufficient number of physicians and doing this in a way which would not imperil the medical needs of the civilian populace. That this was accomplished so efficiently in South Carolina was due primarily to two factors; (1) the untiring activity and rugged honesty of our State Chairman of Procurement and Assignment, Dr. W. L. Pressly, and (2) the day and night work of our older physicians (those of 65 and over) who have carried on the activities of younger men.

Now that the war is over, our thoughts must be directed toward bringing our colleagues home and Dr. Pressly will discuss this in his report. These men must be given aid as they take up their former practices or as they enter new ones. We owe them an obligation which it is not only our duty but our privilege to pay. Furthermore, as Dr. Pressly will explain later, we cannot expect to have as many physicians in South Carolina in the next few years as we did in 1940—and our ratio of physician to population at that time was extremely high. It is incumbent upon us, therefore, to encourage well qualified men from other states to cast their lot with us as they change from military to civilian clothes. And if they come, as we hope they will, we must be able to show them the needy areas of the state and be in a position to help them.

All of this should be an integral part of the work of the Association. At the same time it should be built upon the ground-work which has been laid so well by the Procurement and Assignment Service. With this in view, your Secretary would suggest that this House of Delegates appoint a Committee on Location of Physicians, such Committee to be composed of Dr. W. L. Pressly, Chairman, the President of the Association, the Chairman of Council, the Secretary, and the Executive Director as Executive Secretary. It shall be the duty of this Committee to make such studies and to take such actions as may be deemed wise in rendering aid to our returning colleagues, to help them to re-establish old practices or to start new ones, and to encourage other well qualified physicians to establish practices in

needy areas of the state. It shall be the privilege of this Committee to call upon the officers of the Association, the officers of the county medical societies, and upon any member of the Association for such advice or assistance as may be necessary.

The Ten Point Program

Since the Executive Director of the Ten Point Program will present his own report, your Secretary will confine his remarks to certain general observations.

The Ten Point Program has been in operation for thirteen months and in our opinion has been worth far more to the Association than it has cost.

We are convinced that the greatest need in medical organizations, state and national, is better public relations. We are prone to expect our accomplishments to speak for themselves. We may have definite ideas and even plans for elevating the general welfare of our people but we tend to keep these to ourselves and we do not give the public the benefit of our thoughts. Such a condition plays directly into the hands of those who would have government and non-medical individuals in charge of the medical care of our people.

If we are to assume our rightful place in the vanguard of those who are responsible for the medical care in this state we must throw aside that false pride and reluctance to speak out which has shackled us in the past, and we must make ourselves heard. We must do this individually and we must do it as a state association. But this is not enough in our opinion. We should have a well trained layman, such as Mr. Meadors, who will direct our public relations for us. In the Legislature, in lay groups and in private conversations, he can reach ears and influence individuals in a way which we cannot. He has laid well the foundation during the past—and it takes time to lay a foundation—and it seems to us that it would be calamitous for us not to continue him in his work.

There is no doubt in our mind that government will participate more and more in the medical care of our people. Whether this will be on a national level or on a state level will depend in considerable measure upon the actions of the medical profession. If the medical leadership in each state can present a comprehensive, well-balanced, and progressive plan for the people—and convince the voters of its value—there will be no need for any federal system of medical care.

It is our belief that our Ten Point Program can take care of the situation in this state provided each member of the Association works toward its achievement and provided we are able to "sell the public" on its worth. That there is value in our approach is evidenced by the fact that other medical organizations are adopting the same method of procedure.

Our Program is so arranged that different phases of the work should be undertaken as the opportunity arises. Your Secretary wishes to call your attention to one phase which, in the light of recent developments, he thinks should be dealt with immediately. We refer to the question of hospitals.

Point 6 (a) in our Program pledges us "To study the present availability and facilities of hospitals in the state and to promote the establishment of well-equipped and adequately-staffed hospitals in needy areas."

A large scale hospital construction for the entire country appears to be imminent, and this promises to be particularly evident in those states, such as South Carolina, where the ratio of hospital beds to population is far above the national average. To be of the greatest value such hospital construction should be based upon careful studies of present facilities and a logical appraisal of the findings.

To this end, your Secretary would suggest that this House of Delegates create a permanent Committee on Hospitals. This Committee would be composed of five men to be selected by Council, and the term of office of each committee member would be three years. The President and Secretary of the Association would be ex-officio members of the Committee and the Executive Director of the Ten Point Program would serve as executive secretary.

It would be the duty of this Committee to lead the Association in its work under Point 6 in our Program. As its first task, this Committee would be instructed to confer with the S. C. Hospital Association and with any other organization which is vitally concerned with the questions of hospitals, and to lay plans for an immediate survey of the situation in South Carolina. If, to comply with federal regulations, it is necessary for such a survey to be made by some state governmental agency, it would be the duty of this committee to decide whether it is thought best to use some existing agency or to create a new agency. If a new agency is decided upon, it would be the duty of this Committee to have the necessary legislation prepared and introduced into the General Assembly, and to work toward its enactment.

Another point in our Program which demands immediate attention is Point 9 which deals with our Medical College. Since Council is making recommendations concerning this matter, your Secretary will make no comment.

We would direct your thoughts, however, toward the question of a Medical Service plan for South Carolina. Medical service plans are in operation in many states and before long we will be forced to decide upon a policy for this state. Since this is a matter which would concern every member of our Association we urge that careful study be given to the subject before any action is taken. Your Secretary would suggest that the President be instructed to

appoint a special committee to study medical services plans as they are operated in other states and to report their findings with recommendations to this House of Delegates at its next annual session.

In conclusion, your Secretary wishes to express his appreciation and sincere thanks to Dr. W. R. Wallace, Dr. W. T. Brockman, Dr. F. G. Cain and the other members of Council, to the hardworking and little appreciated county society secretaries, and to all others who have given so much help during the past year.

Julian P. Price, Secretary

The Chair: We have heard this interesting report of our Secretary. There are several recommendations which should receive the consideration of the Association. It seems to the Chair that we should take up these special recommendations of the Secretary one at the time so that we can give them discussion and decide upon them. Will you give up the recommendation, Dr. Price?

Dr. Price: The first two concern policies having to do with membership and annual dues. These have been adopted by the Council, and we ask that the House of Delegates endorse them: (Reading)

(1.) All members of the Association whose dues were paid in full when they entered military service have been carried on the books as members. When these physicians are discharged from service and return to South Carolina they continue to be members of the Association but they are not liable for payment of dues until the first of January following their discharge.

Motion: Motion was made and seconded that the recommendation be adopted, upon vote it was passed and it was so ordered.

(Second recommendation read):

(2) Whenever a physician becomes a member of the Association he is liable for the payment of the regular annual dues regardless of the time of year at which he becomes a member.

Motion: Motion was made and seconded and unanimously passed that this policy adopted by the Council be endorsed by the House of Delegates.

Third recommendation: This recommendation was for the House of Delegates to appoint a Committee on location of physicians. This was made after considerable discussion with Dr. Pressley.

(Reading recommendation): "Your Secretary would suggest that this House of Delegates appoint a Committee on Location of Physicians, such Committee to be composed of Dr. W. L. Pressley, Chairman, the President of the Association, the Chairman of Council, the Secretary, and the Executive Director as executive Secretary. It shall be the duty of this Committee to make such studies and to take such

actions as may be deemed wise in rendering aid to our returning colleagues.

Motion: It was moved, and seconded that this recommendation be adopted. There was no discussion, and the motion was unanimously adopted.

Fourth Recommendation: (Read)

"Your Secretary would suggest that this House of Delegates create a permanent Committee on Hospitals. This committee would be composed of five men to be selected by Council, and the term of office of each committee member would be three years."

Motion: The adoption of this recommendation was moved and seconded, there was no discussion, the motion was voted upon and adopted.

Fifth recommendation: (Read)

"Your Secretary would suggest that the President be instructed to appoint a special committee to study medical services plans as they are operated in other states and to report their findings with recommendations to this House of Delegates at its next annual session."

The Chair: Do I hear a motion?

Motion: A motion was made, seconded and adopted that the recommendation be adopted.

The Chair: We will now have the report of Council, Dr. F. G. Cain.

REPORT OF THE CHAIRMAN OF COUNCIL

Your council at a recent meeting, by resolution, designated that in the future a report of the proceedings of meetings of council be published in the next issue of the Journal in order that the profession might have early knowledge of the problems and activities of the executive committee of your association.

During the past year there have been a few matters acted upon by council of which no report has so far been made and which I will call to your attention at this time.

Under date of December 14, 1944, Dr. Ben F. Wyman, Executive Officer of the South Carolina Board of Health, addressed a letter to each member of council outlining the Rehabilitation Program in South Carolina and requesting a meeting of council to discuss the proposition. At a meeting of council shortly thereafter it was found that the program of Rehabilitation was already in force as a federal and state function and the so-called proposal was, after much discussion, adopted in principle by council. However, council by resolution recommended to the Executive Committee of the South Carolina Board of Health that the fee for professional services be arrived at only after careful study and consultation with the various specialty groups and societies in the

state. This recommendation, I believe, was carried out.

On the same day Dr. Thomas A. Pitts, President of the Board of Trustees, and Dr. L. M. Stokes, a member of the board, presented an outline of the proposed Medical College Expansion Program and requested some action by council on the proposal. Council approved in principle the plan as then presented.

At the annual meeting of council in April, 1945, the contention of Dr. Robert Wilson and Dr. R. S. Cathcart that the election of the delegate to the House of Delegates of the American Medical Association in 1943 was contrary to a long standing rule of this association which provided for the secretary serving as delegate was upheld by council in a resolution acknowledging error in a previous decision on the part of council.

The restrictions necessitated by war made it impossible for a meeting of the House of Delegates to be held at the usual annual season. This necessarily placed an unusual responsibility upon council in that certain vacancies, properly filled by the House of Delegates, had to be provided for because no one could predict when the House might meet again.

I wish, therefore, to officially report that after much debate council determined that since Dr. Thomas Brockman had been duly elected president-elect and while the constitution provides that the president shall serve from one meeting of the House of Delegates to the next, it was the intent that under normal circumstances the term of office should be one year, he, Dr. Brockman, be inducted as president.

Further council felt that certain vacancies must be filled. Accordingly, Dr. A. Richard Johnston of St. George was nominated to be a member of the State Board of Medical Examiners to succeed Captain G. C. Brown from First Congressional district and Dr. C. H. Blake of Greenwood to succeed himself. Dr. Jack D. Parker of Greenville nominated to the State Board of Examination and Registration of Nurses to succeed Dr. J. D. Guess, resigned.

It is respectfully requested that the House of Delegates confirm these actions of council.

Council begs to submit certain recommendations:

Dr. Cain: Before presenting these recommendations I wish to state that at the annual meeting of Council, the Treasurer's report was made and the affairs of the financial affairs of the Association were found to be in excellent state. All moneys expended and received were properly accounted for and later I am going to request the treasurer to present a brief summary of the financial condition of this Association.

Now, I will present the recommendations.

1. Council recommends to the House of Delegates that the annual dues of the Association be raised from ten dollars to twenty dollars.

I will comment a little further on that after I read the second recommendation.

2. Council recommends to the House of Delegates that provision be made by Council for the employment of a public relations officer of the Association whose duty it shall be to carry on the work now being done by the Executive Director of the Ten Point Program and, also, to work with any committees or individuals of the Association who may desire his services, and that the title of such officer shall be Director of Public Relations and Council of the South Carolina Medical Association.

Those two recommendations are made, one somewhat dependent upon the other. You have heard the excellent report by Mr. Meadors of the activities of the Executive Secretary of the Ten Point Program, which has been carried out during the previous 12 months. You have heard remarks of the Secretary, along the same lines. It seems to me and the Council, that Mr. Meadors has done an excellent job. As has been said it is very hard to make a start and we believe he has made an excellent start. Therefore, it is our opinion that this second recommendation should be adopted, and by reason of the adoption of the second recommendation the first recommendation must be carried out in order that the second recommendation can be carried on. Therefore the request for the recommendation that the dues of this Association be raised from \$10.00 to \$20.00. We cannot reasonably expect to depend upon voluntary contributions in the future for the continuation of the Ten Point Program. The profession at large responded in a most remarkable manner to the proposal, and the Treasurer will also read to you, in a few moments, the financial status of the Ten Point Program, but it is quite remarkable that we raised over \$5,000.00 by voluntary subscription to institute the Ten Point Program, but we can't carry it on that way. We have got to have an increase in dues.

I think we have a sufficient membership. If we increase our dues by \$10.00 it will give about \$6500.00 to apply to activities of the Ten Point Program. In addition to that we have about \$3000.00 which was set aside last year, and we believe our profits from advertisements, etc., will enable us to put an additional \$3000.00 in each year, bringing the total, for carrying on and fostering the Ten Point Program, to somewhere in the neighborhood of \$8500.00. We must have an increase in the dues to this Association. As a matter of fact the dues to the South Carolina Medical Association are very meager, even at \$20.00 (if we make them that) compared to many many of the States in the Union.

3. Council recommends to the House of Delegates that all past rules relative to the designation of any

particular officer as a delegate to the House of Delegates of the American Medical Association be rescinded, and that all further elections of a delegate or delegates to the House of Delegates of the American Medical Association be carried on as outlined in Chapter Four, Section 10, of the By-Laws of the South Carolina Medical Association.

4. Council recommends to the House of Delegates that the House of Delegates consider the Medical College Expansion Program as proposed by the Dean and to make provision for careful study and action. To this end the Secretary is asked to read for your information the survey of the proposed Medical College Expansion Program.

(Applause)

Dr. Cain: I move these be taken up, one by one, so that each can be given the proper consideration. (Moved and carried.)

I intended to convey that it would be a part of the Report of Council that the Treasurer read the financial statement of the Association at this time, because, in order to vote intelligently upon the proposals, particularly the first two, the Association should be in possession of the facts as to our financial status at this time so—if Dr. Price is available I think it would be fine for him to give the two financial statements, the statement of the Association, and the statement of the financial condition of the Ten Point Program.

Dr. Price: I was instructed, when the Ten Point Program was instituted, to write a letter to each member of the Association asking for a minimum of \$15.00 as a contribution towards inauguration of this plan. We had hoped to raise \$5000.00. Since we had cleared \$3000.00 in our regular activities I was instructed to place this amount in with the anticipated \$5000.00, making \$8000.00. We believed that would carry us one (1) year. The contributions really amounted to \$5554.09. It might interest you to know, however, that approximately only 40% of the Association membership contributed. In other words, 40% of the members have carried on the work of the Ten Point Program through contributions.

We transferred from the General Account \$3,000.00, giving a total of \$8554.00 with which to carry on the program for one year. The program has been in operation, not twelve months, but thirteen months, and we still have, out of the original amount \$981.00 on hand. I might also add that the Association has as a reserve fund, set up for any emergency that might arise, \$6500.00. It is our feeling that an increase in membership dues from \$10.00 to \$20.00 would give approximately \$6500.00 a year. If we continue to have an excess of income over expense of \$3500.00, that will give us in the vicinity of \$10,000.00 a year with which to carry on the work of a man like Mr. Meadors, and it is going to take just about that much to do it.

The Chair: Now, gentlemen, with these facts before us we are ready to begin the consideration of the recommendations of Council. We will ask you to read again Item (1).

(Dr. Cain reads the 1st recommendation.)

Do I hear a motion?

(It is moved and seconded that the recommendation be adopted.)

Is there any discussion?

If you have anything to say, say it now or forever after hold your peace. I hear no discussion.

(The motion was put to a vote and unanimously carried.)

(Dr. Cain reads the second recommendation.)

The Chair: You have heard the recommendation and with the splendid report we have heard this evening I can hardly see how we could afford to vote but one way.

Dr. Price: May I make one observation. At the present time Mr. Meadors is an employee of the Council of the S. C. Medical Association. Under this resolution he would become an employee of the House of Delegates. You can see the difference. Furthermore, he would be at the call of any committee or any individual in the Association for help. At the present time his activities are tied down by action of Council.

Motion: Motion is made and seconded to adopt the recommendation of Council, the question was put (since there was no discussion) and the motion unanimously passed.

(Dr. Cain reads recommendation No. 3.)

The Chair: Chapter 4, Section 10 of the By-Laws of the S. C. Medical Association specifies the delegate shall be elected to serve a term of two years.

Motion: Dr. Guess moves the adoption, and this motion is seconded.

The Chair: Is there any discussion?

Delegate: Does that mean the delegate will be elected without regard to office?

The Chair: That is the idea. He is to be nominated from the floor. Is there any other question or discussion?

(This motion was voted upon and passed.)

(Dr. Cain reads the recommendation No. 4.)

Dr. Cain: This recommendation is merely that we go ahead and consider this proposition and take action and study it and get busy and do something about it. That is what the resolution means.

Motion: The adoption of Recommendation No. 4 is moved, seconded (no discussion), voted on and passed.

Dr. Cain: Mr. President, the request is that the Secretary be asked to read this proposal of the advisory committee in order that the gentlemen be informed before they act upon this proposal.

Dr. Price: Has everybody a copy?

Dr. Dibble: I would like to suggest that since we have had a good deal of talking, and there is going to be a whole lot more, why not let the men read this survey and skip this?

Dr. Price: It has been suggested that we pass over this hurriedly, only reading by title most of the paragraphs, and reading in detail one or two that are of particular interest to us at this time. (Certain paragraphs are read aloud, as follows: Rating, Relation to Roper Hospital, Research, Free State Hospital, Fees to be Charged, Organization, Financial consideration, Conclusion.) (Full report published in this issue of the Journal.)

Dr. James McLeod: Mr. President, members of the House of Delegates. At a meeting of Council, held several weeks ago, I was asked by Council to speak to this report. There is no doubt that the survey that has just been read by Dr. Price is a very comprehensive one, one that merits the serious consideration and study of every member of this Medical Association. There is no doubt in my mind that if this plan, this survey, this program is carefully studied by every member of the Association, (you all have it in your hands, and it is to be printed in the November issue of the Journal of this State Association) and then endorsed with enthusiastic approval, there will be no difficulty in its successful culmination. I am quite sure, also, that if after the members of the Association have had opportunity to study this program it is not enthusiastically endorsed, it should be dropped. If the Medical Association of South Carolina is not for this program, how in the world do you expect the members of the General Assembly to be for it, or the rest of the citizenship of our State? I would like to say this, and I am making no reflection on this splendid survey or on the laborious work of this splendid committee in the past several months, that in my opinion the present status of the program is due too largely to lack of familiarity of the Association, at large, with the program, and a lack of the opportunity for a free discussion of all it involves.

Therefore, that being my opinion, I am going to present the following resolution: That the survey, that has just been read by Dr. Price, the report of Dr. Lynch and his associates, be received by this House of Delegates as information; and that the House of Delegates empower Council to appoint a committee of 16 members of this Association, one member from each judicial circuit, together with the President and Secretary of the Association, and as Executive Secretary and counsel, Mr. Jack Meadors.

That will form a committee of seventeen (17).

There will be one man from each of the 14 judicial circuits in South Carolina. That one man could call a meeting of all doctors in his Judicial Circuit and could present the survey and discuss the pros and cons. When the Committee of 16 is brought together each member could bring an opinion from his section of the state. If as a result of that study it is deemed wise to have it approved by the Association, I would suggest that we have a special call meeting of the House of Delegates to consider the report of the Committee.

As I said in the beginning, if this program does not have the enthusiastic endorsement of the men of the Medical profession, I think it should be dropped. This is a monumental thing, the biggest thing that has come before the State Association and I believe it should be given most careful study and consideration.

The Chair: Gentlemen, you have heard Dr. McLeod's motion. Is there a second to it?

(The motion is seconded). Is there any discussion?

Dr. Cain: I am heartily in accord with something being done, and something very drastic being done. I would like to point out that if the medical profession of South Carolina is to get behind this proposal, perhaps we have to act a little bit more quickly than Dr. McLeod has indicated in his motion. As I understand it, the South Carolina Budget Commission and the State Planning Commission begin to hold meetings perhaps in November and it is important we get our recommendations to these committees at an early date. I would just like to drop those remarks in connection with Dr. McLeod's motion.

Delegate: Am I correct in believing that we have already adopted the recommendation of Council that we endorse that program?

The Chair: At a meeting of Council sometime ago the expansion program was approved in principle.

Delegate: I mean a few minutes ago did we not vote to adopt it. Before the report was read, didn't we take a vote to adopt a recommendation of Council? Did not someone make a motion that we accept that recommendation, and wasn't that motion seconded?

Dr. Cain: That recommendation was not to "endorse," it was to "consider."

The Chair: Is there any other discussion?

Dr. Young: As Dr. Cain has just remarked, the motion was that we consider and take action. I think we are all in accord with what Dr. McLeod has just said, but we are all here now, this is the House of Delegates, and for all of us to get back between this and the 1st of January, might be difficult. I believe we are in just as good position this afternoon to endorse and plan for action as we might

be at a later date this year. It has been before most of our County Medical Societies and any apparent lack of enthusiasm or support has been due to innate laziness or business. Most of us have been terribly busy. I believe we are in just as good position this afternoon to give this action and support as we would be 30, 60, or 90 days later.

The Chair: Are there any other remarks?

Did you want to formulate that into an amendment?

Dr. Young: I hadn't thought of it, I could. I would like for Dr. McLeod to make a new motion to that effect.

Dr. McLeod: The resolution which I presented is the result of serious study and consideration. It has been my privilege to be associated with the Medical College Expansion Program and to have had the opportunity to study the survey which has been presented. On the other hand the members of the House of Delegates have seen the survey for the first time today and there has been no opportunity for the members to read and study this important document.

This survey deserves the serious consideration of every member of the Association and of the House of Delegates as a whole. It is my feeling that this committee of sixteen with its widespread distribution would give an opportunity for thorough study. This committee might be called upon to meet several times as a group and the members of the committee would be expected to make investigation and perhaps to hold hearings in their own communities. To me such a plan of procedure is the most equitable one which could be devised.

I do not believe there is any member of the Association, particularly of this House of Delegates, who would not give of his time freely toward a progressive move in behalf of our Medical College and that is the reason I advocated a call meeting of the House of Delegates. As members of the Association we must not only familiarize ourselves with this entire program but we must work together. It is imperative that we present a united front to the public and to the General Assembly. Our Association cannot afford to sponsor a plan of this type which will be so far reaching in its consequences, without the enthusiastic support of all of our members.

With dignity and with humility and with certainty in my purpose I again ask you to adopt this resolution as it was introduced. I sincerely believe that this would be the most effective way in which to handle this problem.

The Chair: All in favor of Dr. McLeod's motion say "aye."

(There were some "ayes.")

All opposed "no." (There were some who voted "no.")

The Chair: It appears to the Chair the motion is carried.

Dr. F. G. Cain: Mr. President, the Credential Committee has a problem.

The Chair: What is the problem?

Committeeman: Dr. Herlong, from Rock Hill, had us seat a delegate as an alternate and we find he is not from York County. We will let Dr. Herlong come up and explain that and let's see what we can do about it.

Dr. Herlong: One of the delegates from York County could not come. I found a man from our neighboring sister County and asked him would he serve as an alternate for Dr. J. B. Elliott, and I wrote it down that way. I would like to know if there would be any objection, since Dr. Elliott could not come.

The Chair: The Chair will rule he is not eligible to serve as a delegate from your County unless he is a member of your County Society.

The Chair: I will not call on Dr. F. G. Cain, Special Order.

Dr. Cain: Fellow members, I didn't know the Chairman of Council had so much work to do. However, on this particular occasion I have a special honor and privilege of performing what to me is a very pleasant duty. It has been the custom of this organization to present to its retiring president some small token of our love and appreciation for his services to this Association and the sacrifices he has made in its behalf. When one is elevated to President of the South Carolina Medical Association, this fact in itself indicates that the individual has already served well the efforts of organized medicine. In addition to this the position of president necessitates a special effort and self-forgetfulness in order to fulfill the obligation of the office. These things our retiring president has done well, with much credit to himself and benefit to the Association. Dr. Wallace, it gives me great pleasure on behalf of the membership of the South Carolina Medical Association to present you with this little gift, and we trust that it will serve well in helping you to keep track of time for many happy years to come. (Applause)

Dr. Wallace: Mr. Chairman and fellow members of the Association, I am overwhelmed by this token of your esteem and appreciation. I assure you that I appreciate this very much and it shall be one of my cherished possessions. I shall cherish it, not so much because of its intrinsic value but I cherish it particularly because of what it represents. I feel it is an honor to be President. I am very conscious of the fact that any administration, without an annual meeting, seems somewhat incomplete and for that reason I doubly appreciate this because I feel that my administration still leaves something to be accomplished, which was, of course, ordered

by the Government. I wish to thank each one of you very sincerely for this mark of your esteem and I shall always cherish and remember the two years of very pleasant association with the members of this Association. (Applause)

Dr. Wallace: We will now ask the real President to take over the responsibilities of the meeting. Dr. Brockman.

(Applause and entire convention stands.)

Dr. Brockman: Dr. Wallace, and members of the House of Delegates, and friends, I feel lots better now that I have been remarried. I don't have any kick, for things have been upset due to war conditions, I have gone ahead in a small way and tried to carry on. I have felt like I wouldn't really technically be your President until you had this House of Delegates meeting and I am awful glad to welcome you and be a part of you today.

For several weeks I have pulled my hair as to what I was going to talk about. There were so many things which I could discuss. I considered talking about these boys coming home, but there wasn't so much I knew to say about that. But, I have done one little thing. I think it is the least thing I have ever done, and before I talk to you on the main subject I want to talk to you about it.

A few weeks ago one of our doctors came home on a visit and he came around to see me. He said he would be home for good within a week, he thought, and had already spent an entire week searching for some place to use as an office. He had been in practice five years before he had gone into the Service, and he had been gone four and one-half years, and he didn't have an office. There are a lot of boys like that. I see two or three in the back of this hall now in the same boat. There was something about this doctor's expression that kept staying with me. I was leaving for a Council meeting, the last day of August, when this experience occurred and on my way down I asked myself this question: "Are you going to ask the Council what to do about these boys? What are YOU going to do?" I said, "What are you going to do about them when they come back? Is there anything you can do? If you can answer that maybe Council can answer it." The thought occurred that I could share my office with this boy, my own private office.

When this soldier doctor came home I went to him immediately and offered to share offices and he is now coming in the morning and staying until 12:00 o'clock. I come in at 12:00, because I generally spend the morning hours in the hospital. In the afternoon we stagger our hours and it is working out fine. It is giving him a chance to go ahead and some of these days he will find some quarters. I think he is practically located. I think he will have to renovate the place and rework it, but he has found something. I would like to offer this story

for your consideration.

WHY DOES SOUTH CAROLINA NEED A BASIC SCIENCE LAW?

For its own protection, the public should be well acquainted with the method of selection, the qualifications required, and the licensing of men in medicine, and the reasons why the medical profession opposes the quack, the cultist, and the irregular practitioner. It should know the motives actuating those who emphasize the necessity of a basic scientific education before entering or practicing any branch of the healing arts.

I am in favor of a basic science law which ignores all medical dogmas and cults. It establishes an impartial, nonsectarian board of examiners in the basic sciences, anatomy, physiology, pathology, chemistry and bacteriology, and requires that each person who desires to obtain a license to treat human beings, as a first step toward obtaining that license, appear before that board and demonstrate his proficiency. Only after having obtained from the board a certificate of proficiency in the science named can the would-be practitioners appear before the professional board of his choice for an examination to determine his ability to apply his knowledge professionally.

Let us notice the part that science has played in the development of the greatest of the healing arts, i. e., Medicine.

Perhaps your great-great-grandfather was a doctor, but he never went to medical school. He was a blacksmith who bled people and pulled teeth. Perhaps your great-grandfather was a doctor and graduated in 1821. He bled and he blistered and he puked—and he purged—and this was about his armamentarium. He didn't even have ether or chloroform.

Perhaps your grandfather was a doctor and graduated in 1857. Bacteria was unknown. His appendicitis patients died of "cramp colic" and "locked bowels." He didn't know that tuberculosis was communicable. He did not have a fever thermometer.

Perhaps your father was a doctor and graduated in 1884. Diphtheria was rampant and deadly, and so was typhoid fever. He did not have vaccines, for them, nor thyroid extract, nor adrenalin, nor pituitrin. Blood transfusion was unknown. He didn't even have an X-ray. Radium had not been discovered. He did not have local anaesthetics. He could not even take a blood pressure. Pathological and clinical microscopy was just beginning. He didn't know that yellow fever was transmitted by mosquitoes, nor had he heard of hookworm.

Perhaps you are acquainted with a doctor who graduated in 1900. He did not even have insulin for diabetes, nor liver extract for pernicious anaemia, nor scarlet fever serum, nor the malarial treatment for paresis, nor a host of other things.

Yet in a little more than a century, the medical profession has done more for the race than has ever before been accomplished by any other body of men. These gifts to the people have come in the form of vaccination, sanitation, anesthesia, antiseptic surgery, the new science of bacteriology and the art of therapeutics. The increase in scientific knowledge of the human body has been marvelous, and the understanding of the cause and cure of many diseases has made tremendous strides.

What is the cause of all this comparatively recent burst of progress. The reason is apparent when we realize that during this same period there has been an enormous increase of scientific medical education.

In pioneer times, a basic scientific education was regarded as a luxury beyond the dreams of many students of the art of healing. Thousands of youths became physicians and surgeons by entering the office of a busy practitioner. It is scornfully asserted that they studied medicine by sweeping out the office, running the doctor's errands, polishing his instruments, and holding his horses. Is there any wonder that very little medical progress was made.

If a Basic Science Law is put into force in South Carolina, we will know, without looking further into the matter, that every person engaged in the healing art has presented the necessary qualifications, has done the required amount of class work, has attended the requisite number of clinics, and has successfully passed his final examinations to the satisfaction of the school authorities and of the state health boards.

The purely scientific side of the art of healing—investigation, research, discovery—is a field in which genius can find all the intellectual and other satisfaction that even it can hope for. The problems are as intricate as any that concern man. The solution of these problems offer rewards in service to mankind that are among the greatest that altruism can wish.

Fortunately, the possibilities of investigation and of discovery are not confined to a few great men. Every patient is more or less a problem. In the healing arts, more than in any other vocation that I know, the rank and file (*if they have a background of basic scientific education*) are constantly stimulated by their experiences to suggest new ideas and almost every practitioner occasionally makes some new observation or develops some useful idea in practice. However, unless they have a basic scientific education, they will fail to recognize their opportunities to add their lasting contribution to humanity.

The objection might be made that too much emphasis upon scientific education will blind the practitioner to the "human" side of the art of healing. Such, however, need not be the case. Instruction in the sciences can be correlated with history to show how man's increasing knowledge of the physical order

has affected his health, his industries, his intercourse with his fellow beings in war and peace. Much can be made of the biographies of men who have contributed to the common heritage. Thus, scientific students may appreciate the dependence of past and present upon the efforts of those who have gone before, catch the inspiration of lives dominated by lofty ideals, profit from the secret of their success, and remember the undying contributions of the heroes of peace.

A scientific course can clarify the student's understanding of the meaning of law inasmuch as the natural sciences deal with a realm of eternal principles with the caprices and feelings of mankind neither create nor alter.

In the daily methods of science study, attention is directed to the importance of open-minded investigation, the need of reserving one's judgments until one possesses the necessary facts, and the duty of reporting observations accurately.

In view of these considerations, it is plainly seen that a Basic Science Law enacted and enforced by our State could not fail to increase the possibilities of all practitioners in the art of healing to make valuable contributions to the scientific progress of their profession, and, at the same time, to raise the professional ethics and the human understanding of all doctors.

It is the duty of each citizen to take a constructive interest in the cause of healing and rally to the support of a measure that will elevate the standards of those who guard our most precious possession—Health.

I am strong in my faith and firm in my conviction that you will aid, through your demand that a State Board be selected to certify a man's ability to enter the healing profession.

(Applause)

The Chair acknowledges Dr. Cain—

Dr. Cain: I am very sorry to have to ask the House of Delegates to bear with me a moment, but as Chairman of Council a request was made in Councilors' report for confirmation of the action taken by the Council relative to the nomination of certain gentlemen in order that certain board vacancies might be filled. It seems to me, for the purpose of keeping the legal record straight, this House of Delegates should confirm the legal action of Council, or as they otherwise see fit. I would appreciate someone making a motion confirming the action of Council and recommending to the Governor these men for State positions.

Motion—A motion was made and seconded that the House of Delegates confirm the action of Council in recommending these men on these various examining Boards.

The Chair: Is there any discussion?

(The question was put and unanimously passed.)

All of the committee reports have been published in the Journal. If you would like to hear them we will start and hear them. Our first one is a report of the Executive Committee State Board of Health, Dr. W. R. Wallace, Chairman. Dr. Wallace.

Dr. Wallace: Gentlemen, I am not going to read a report of the State Board of Health. As you probably recall, the report was printed when first reported to Council in April and put in the May issue of the Journal. I will call your attention to several items so that I may bring up to date the affairs of State Board of Health.

First of all, there has been a change in the personnel of the Executive Committee. Dr. Lynch, who served so well for a number of years, and most of the time as Chairman, on account of his duties at the College had to resign and I was appointed to succeed him.

There are two or three items I would like to mention. Dr. Frank Parker died recently. For a number of years Dr. Parker's laboratory examined the water supply of South Carolina. The law was that each municipality and utility furnishing drinking water must have these samples examined every quarter and must pay a fee of \$5.00 for examination. We find a great many municipalities never had their water examined. Since his death we feel the State Board of Health can render an unusually effective service by taking over the examination of the water supply and putting it under the laboratories of the State Board of South Carolina. When this is done we will examine water, not as it has been done, but more frequently. It will be examined once each month. The samples will not be collected by the management of the water plant, but they will be collected at certain points in the city so that it will be a true condition of the water that is examined and will be collected by some member of the Board of Health personnel. At certain times of the year chemical examination of the water will also be made.

We expect to make plans to control swimming pools. We are not going to take samples on Monday morning when the water has been changed and is fresh, but later in the week, particularly on Saturday. We feel this can be made a most valuable addition to the Public Health facilities of this State. This can not be put into effect until additions are made to our present personnel and until the legislature will approve the expenditure of the necessary funds.

The next item is the Bureau of Vital Statistics. We feel a great deal of progress has been made in this Bureau, but it only shows that a great deal more can be done. The Census Bureau in Washington loaned us a man who has been down and gone into our methods of keeping records. The War brought

on unprecedented demands for birth certificates and now we are very conscious of the deficiencies of our methods of keeping records. Most of our records have been turned, twisted, looked at and turned until almost worn out, and there are still a great many people who are not able to find their official birth certificates and could not establish their right as citizens of South Carolina to certain privileges and allotments that they are entitled to. We are in the process of revising the records and methods. We are going to put in tabulating machines so that we can run cards through and get information that is worth something.

One other innovation is the collecting of the statistics of the Bureau through the County Health Agency. We do not recommend that registrars in any districts of South Carolina be abolished, but that they first send their reports through the County Health doctor, so that all the unnecessary and voluminous correspondence that goes on every day in writing back to the doctors and midwives to complete the reports can be avoided to a large extent. And, we expect to give with each birth certificate a small miniature card, which will have the necessary facts and which will be accepted as a birth report. That will be of great value and will lessen to a large extent the tremendous number of applications that are coming every day into the Bureau of Vital Statistics.

At this particular time, great progress is being made in the treatment of venereal diseases with the advent of penicillin and the sulfonamides, and certain methods being used, and we feel the State Board of Health will do a good service in evaluating the methods and the drugs that are giving the best results.

We also are asking the State Medical Association to appoint two doctors, preferably from somewhere in the vicinity of Columbia, who are available, and two druggists, who will consult with the State Board of Health on Drugs and Biologicals. The druggists have already appointed two, and we hope that two doctors will be appointed by this Association.

Ten minute recess taken

The Chair: We will now have a detailed report of the Credentials Committee. After this report is read, I will ask the delegates to occupy these front seats so that the tellers, when we get into the election of officers, can keep up with you better. You folks with badges on sit in these front seats.

Dr. Sease, will you come and give your report of the Credentials Committee?

Dr. Sease:

Delegates present	61
Past Presidents	13
Council	9

President-Elect	1
Secretary	1
Medical Examiner	1
Vice-President	1
Total	87

The above tabulation is a report of the committee on credentials.

Signed

Thos. G. Goldsmith

J. C. Sease

Robert Wilson, Jr.

Dr. Dibble (Recognized by the Chair): I move that the committee reports that have been published in the Journal be omitted, unless some new matter is to be reported to the House of Delegates.

The Chair: You have heard the motion that the reports that have been published in the Journal be omitted.

(The motion was seconded; there was no discussion, and the motion was passed.)

Is there any Old Business?

Is there any New Business to come before the House?

Dr. Price: Mr. President, we had decided to have the spring meeting in Greenville. That meeting was called off. According to the Constitution it is up to the House of Delegates to decide upon the place of meeting. Greenville has extended a very cordial invitation for us to meet with them next April but it will be up to the House of Delegates to decide whether we will meet in Greenville or not. Council will make the decision as to the date.

Dr. Sasser: I would like to extend an invitation for you to meet at Myrtle Beach next year. I think it is time to go there and we have the hotel facilities and would like to have you.

Dr. Guess: Mr. President, gentlemen of the House of Delegates. Greenville was very disappointed when we could not entertain the State Association last year. We had gotten our plans pretty well finished before we found we could not have that pleasure. Our plans are already started to entertain you next April and I hope when this question is put, although I would love to go to Myrtle Beach, and I hope we will go there soon, I hope you will vote to come to Greenville. We all want you, we will try to make you happy and we welcome you and hope you will come meet with us next spring.

Dr. Herlong: If Greenville will promise to give us an old time state meeting, we will vote to meet there. I move that we go to Greenville.

Dr. Cain: I second the motion. I would love to go to Myrtle Beach, it is closer to my home than Green-

ville, but the Greenville boys went to a lot of trouble last year and we could not go. Dr. Sasser can keep his invitation open.

The Chair: You have heard the motion that this Association go to Greenville next April or whenever the meeting is,—is there any discussion?

Motion put and carried.

The Chair: We are now ready to go into the election of officers. I am going to appoint three past presidents as tellers:

Dr. W. L. Pressley.

Dr. W. Atmar Smith.

Dr. W. R. Wallace.

The Chair will entertain nominations, first for President-Elect.

Dr. O. T. Finklea: Gentlemen, I wish to bring before this Association the name of a man who has been connected with organized medicine in this State since the beginning of his medical life; a man who has been willing to work for organized medicine and to do what he thinks is best for it; a man whom I know to have energy and who is willing to expend that energy for the betterment of organized medicine; a man who is not too bashful to approach and talk with the greatest and yet not too almighty to hobnob with the most humble; a man whom I know will give this organization a good administration, and whom I know will go and join with that band of great men who have already had this honor bestowed upon them. It gives me one of the greatest pleasures of my life to nominate my colleague and very personal friend, Dr. James McLeod of Florence.

Dr. Cain: I am glad to second the nomination of a man of such caliber as Doctor McLeod and ask you all to help us join with the Pee Dee Section and elect him President today.

Dr. Robert Wilson, Jr.: I would like to add my second to the nomination of Dr. James McLeod, a private practitioner.

Dr. J. A. Sasser: I want to third that nomination of a good friend, a counted surgeon, and a leader of medicine and surgery in the Pee Dee Section of this State.

Dr. A. F. Burnside: I want to nominate, in behalf of the Columbia Medical Society delegation, a representative from our Medical Society, a man whose family have been practicing in South Carolina, doing private practice, for 116 years, Dr. Ben F. Wyman.

Dr. Hugh Wyman: I would like to second the nomination of Dr. Wyman for two reasons, first because I know him, believe in him; I think he is the safest man we could have under the circumstances. As our State Health Officer with his background of being brought up through a family of

doctors I know he will never turn his back on the private practice of medicine. Secondly, because I am blood kin of him and I think well of myself. That is why I would like to second it.

Dr. Nackman: I move the nominations be closed. (This motion was seconded; there was no discussion; the question was put and unanimously carried.)

The Chair: You will prepare your ballots for President-Elect for Dr. James McLeod of Florence or Dr. Ben F. Wyman of Columbia. (The votes were cast and the tellers collected them.)

The Chair: Will Dr. George Thompson come to the front? I want to take this opportunity to present to the House our Vice-President and I am going to ask him to say a few words. I have served with him on Council, I know how faithfully he has served, and it gives me pleasure to present Dr. George Thompson of Spartanburg. (Applause)

Dr. George Thompson: Gentlemen, I always had an idea Vice-Presidents are sometimes like the child in the family, they should be seen and not heard, too much. It is a great pleasure to be here today and to be serving as Vice-President.

I have been a member of the County Medical Society ever since I was a doctor, almost, and have always been benefited and interested in the medical meetings. The President and I were neighbors for a very long time and I knew him when he was a general practitioner. He got away from that and I am a general practitioner still.

I feel somewhat like the colored boy when they were taking his case history and they asked him what disease his brother died of, he said, he didn't know but it wasn't nothing serious. The next question was, "What doctor did you have?" And he said, "Well, we didn't have no doctor, he just died by himself." (Applause).

The Chair: We are ready for the report of the tellers.

Dr. Smith: Dr. McLeod — 57 votes. Dr. Wyman—28 votes. (Applause)

The Chair: We will now hear nominations for Vice-President.

Dr. Herlong: I want to nominate a man who is running Dr. DesPortes man a close second in years and hard work. I want to nominate a man who is a graduate of Erskine College, a first honor graduate of Vanderbilt Medical School, a veteran of World War No. 1, an outstanding surgeon in this State, who has done quite a bit towards the advancement of medicine. He has been influential in bringing several outstanding men to his city in an effort to advance medical science in his city. He is not a graduate of our State Medical School but he has contributed largely to the State Medical School, Dr.

W. D. Ward of Rock Hill.

Dr. Burnside: I second Dr. Ward's nomination.

Dr. Black: I wish to move the nomination of a man who has done a great deal for medicine in South Carolina, a great gentleman and a fine fellow, —I want to nominate Dr. Marvin Dibble of Marion, S. C.

Dr. Assey: I second the nomination of Dr. Dibble.

Delegate: I move the nominations be closed. (This motion was seconded and passed.)

The Chair: Before we prepare a ballot, I want to declare Dr. James McLeod elected President-Elect. Now, you may prepare your ballots for Dr. Ward of Rock Hill, and Dr. Marvin Dibble of Marion, as Vice-President.

The Chair: One report was not published, Dr. Pressley's report on Procurement and Assignment. Dr. Pressley.

Dr. Pressly: I want to thank you for the opportunity of serving you another year. I have gathered some facts that I thought would be of interest to you doctors. The life of Procurement and Assignment is lengthened to December 31. We have a secretary up to that time. The problem is now the returning doctors in the state.

I thought this fact would be interesting to you. When the order from Selective Service came out about three months ago that everyone up to 38 years of age must be certified (with doctors we only certified two classes; that is, doctors from 18 to 29 and from 29 to 33), you will be surprised to know of the young doctors left in the state at that time. We only had to certify 23. The Procurement and Assignment Service was designated as one of the certifying agents, with Code No. 15, and the doctor had to be certified with his local board or he was subject to draft. When I went through all the cards I was surprised to know that there were only 23 men who had been especially requested to remain out of the army. I trust we did not do these young men an injustice. All 23 have appealed to go into service. A few had to stay by to do some special job, some in hospitals, the State Board of Health and the Medical College.

That will bring us to the age group of 33 to 40. In the state at present there are 139 doctors from the ages of 33 to 40. From the ages of 40 to 50 there are 197. Here is a surprising group—from the ages of 50 to 60 there are 298 doctors; from the ages of 60 to 70 there are 218, which totals 516 doctors between the ages of 50 and 70. That is rather alarming. Here is a grand old group, from 70 to 83, and that group contains 109 doctors who are actively engaged in practice. (Applause). My hat is off to them.

We have 87 doctors in the state who are retired, and we have 26 women doctors. That gives us a total in the state of 1038 doctors, and with 287 doctors in the army, a grand total in the state of 1325. Two hundred eighty-seven represents the doctors that South Carolina has furnished to the Services. Not everyone was in an established practice, but many boys who had finished an internship and residency went directly into the army. The population of South Carolina as I can recall was 1,800,000 as of 1940—I figured it on a basis of 1,800,000. That gives one doctor to each 1,908 people, including specialists. There were 1409 doctors in the state at the time I was president in 1941. The deaths have been rather heavy in the older group.

Now, according to the last directive from the Surgeon General's office, any doctor over 48 years of age is automatically discharged unless he has a specialty rating that makes it necessary for him to be retained. The psychiatrists are hit pretty heavy; and the eye, ear, nose and throat men. We have a boy in our section, 50 years of age, in both World Wars, and he has been held up but will be out in a few weeks. Also, anyone who has 80 points or has entered the service prior to December, 1941, is automatically out. I think that in this state we will return, right away, 125 doctors, that is in round figures; we may return a few more, or less.

Now the Navy has been very tight but they are out with their program. They are going to release a lot of doctors. Our great problem is the returning doctor. We have on record in our office the distressed areas and we have been able to place the doctors where the need is greatest.

Captain Melcher returned about four weeks ago; he had never been in practice, and I referred him to several towns: Iva, Fountain Inn, and Branchville. He selected Iva. The town built him an office, and furnished it and a home also. Communities are awakening to the fact that they must make things more attractive to a doctor in order to get a good man to locate. That is a very good sign that communities are encouraging doctors to locate with them. That is a well-trained man and he will give service to Iva and Lowndesville. He will render a great service there.

I want to thank the State Board of Medical Examiners. We have been in distress in several communities. There was a mill village at Lockhart, South Carolina without a doctor. The State Board of Medical Examiners allowed us to use a B-Class school to fill in for the emergency and the doctor was notified after the emergency was over that he would not be asked to remain.

I was delighted to have a meeting recently of the State Medical Association officers: President Brockman, Secretary Julian Price, and Executive Director Jack Meadors; and we discussed the problem of the

returning doctor. We decided that we are going to pitch this on a county level. Within the next ten days this committee will meet again and we will select one man from each county. He will in turn select whom he wants to advise with him, and they will list what they consider their medical needs are, taking into consideration the returning doctors to their respective locations. We will have this data and will be able to advise anyone wishing to seek a location in South Carolina, whether he be a pediatrician, surgeon or what not. Probably the greatest need is the general practitioner. Towns the size of Columbia, Greenville or Spartanburg can take care of themselves, but this rural practice is urgent. We must make it attractive to these boys to go out there. It can be done, and I feel we are going to be able to accomplish something along this line.

One other thing—the Procurement and Assignment Executive Committee met with Army and Navy officials in Washington a few weeks ago and the different branches of the service notified us that the doctors educated at Government expense will be called at the end of their internship and residence; and each succeeding class will be called. As to the length of service for which they will be called, they do not know; they do not know what the emergency will be. That will mean here, with about 625 doctors between the ages of 50 and 80 years of age, there is going to be a period of about 3 to 4 years without many young doctors entering practice. Those young doctors, educated at Government expense, are not going to get back soon. We must postpone our vacations and hold on. The going will be tough.

I should like to read this letter, to put the praise where it belongs; first, to the boys in the Service; second, to the Councilors of the districts, for I have only been their tool. This letter is from the Surgeon General of the Navy.

Dr. W. L. Pressly

Box 216

Due West, South Carolina

Dear Doctor Pressly:

In view of the victory over Japan the Navy Department has discontinued processing applications from civilian physicians for appointments in the Medical Corps, U. S. Naval Reserve. As you undoubtedly know provision has been made for the orderly demobilization of Naval personnel and Naval Medical Reserve Officers will be returning to civilian activities in ever increasing numbers.

The State and Vice Chairman of the Procurement and Assignment Service have established an enviable record of achievement in the performance of the difficult duties assigned them. In the past few years I have been frequently informed by a large number of Naval and civilian personnel regarding the outstanding work performed by the Procurement and Assignment Service. Very few are cognizant of the

enormous amount of work involved in connection with the duties assigned to the Procurement and Assignment Service and the fact that these duties were accomplished on a voluntary basis with no financial remuneration.

You have contributed a distinguished service which had considerable effect on the war effort. The Medical Corps of the Navy joins me in expressing sincere appreciation and a "Well Done" for your splendid work and assistance to the Bureau of Medicine and Surgery.

I wish to reiterate my personal appreciation and thanks for your patriotic services rendered to the Medical Department of the Navy during World War II.

With kind regards and best wishes, I am,

Sincerely,

ROSS T. McINTIRE
Vice Admiral (MC)
Surgeon General, U. S. Navy

That is a word of appreciation from the Navy.

In Washington, about three weeks ago, Dr. Frank Lahey, head of Procurement and Assignment Service, said that we have had in the state of South Carolina as orderly an induction of doctors into the service as any state in the Union. This was due to the fact that such men as Frank Cain, Bob Durham and other members of the Council did a splendid job of their responsibilities; and I am sincerely grateful. (Applause).

Dr. Herlong: What is the Committee doing or what do they think? How are we going to get them into the rural sections? How are you going to make it attractive?

Dr. Pressly: I just cited the ease at Iva — they are furnishing the doctor with a well-equipped office, with X-ray and laboratory.

Dr. Herlong: I think that is what is bringing up this State Medicine, the lack of doctors in these rural communities.

Dr. Pressly: I can only speak of the Piedmont Section, where I know the towns. This committee must place it on a county level, for we want each county to be responsible for the requests. We do not want anyone to say that the Procurement and Assignment Service sent a doctor they didn't need. With that I believe we can make it attractive for the doctor to locate in the smaller town. I am in favor of getting the young doctors to work as soon as possible and not spending too much time in post-graduate work, as the responsibility of a general practice is the best post-graduate work possible.

The Chair: I will ask Major Kilgore Webb, a recently returned doctor from Europe, and another doctor, Major Lesesne Smith, to escort the New

President-Elect to the Chair. (Clapping and all rising as Dr. McLeod is escorted to the speakers' table.)

Fellows, meet the new president-elect of the South Carolina Medical Association, Dr. James McLeod of Florence.

Dr. James McLeod: Mr. President, members of the House of Delegates. I wish to assure you I appreciate very much the expression of confidence that you have given me here this evening. I accept it in deep humility. If I can in some way repay the deep obligation that is in my heart to this Association, I will be very, very happy indeed, and I wish to assure you that I pledge to you my very best efforts to promote organized medicine and to promote the South Carolina State Medical Association in the State of South Carolina. (Applause).

The Chair: We will hear a report from the tellers on the election of Vice-President.

Dr. Smith: 57 votes for Dibble; 25 for Dr. Ward.

The Chair: Dr. Dibble is declared elected Vice-President. Congratulations.

Dr. Dibble, stand up and be recognized.

Dr. Dibble: (Standing) I only can say I thank you very much.

The Chair: I will now hear nominations for Secretary.

Dr. Evans: I think good work should always be appreciated. We have had a Secretary who has had a most progressive term, who has been very conscientious in his work and I wish to nominate Dr. Julian Price to succeed himself.

Delegate: I would like to second that nomination. I think he is worthy, has proven himself so, and it is an honor to second the nomination.

Dr. Cain: I move Dr. Price be elected by acclamation. (This motion was seconded.)

The Chair: It has been moved and seconded that Dr. Price be elected by acclamation, all in favor say "aye." "Aye." All opposed "no." (There were no no's, the vote being unanimous for Dr. Price.) Dr. Price, you are re-elected Secretary. (Applause).

Now, you have to elect a Treasurer.

Dr. Hayne: I move the present incumbent be elected. I move that Dr. Price be re-elected Treasurer. (This motion was seconded, the question was put, voted on, and Dr. Price was unanimously elected.)

The Chair: Dr. Price you are Treasurer.

We have three councilors to elect, it will really be four, for Dr. McLeod's place will have to be filled.

First District, incumbent Dr. F. G. Cain. We will now have nominations from the first district.

Dr. Walsh: I would like to place in nomination the name of J. W. Chapman, Walterboro. He is a



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good practitioner, a level headed man with a good mind and very much interested in organized medicine. (This nomination was seconded.)

Dr. Van de Erve: I nominate Dr. Robert Wilson, Jr., of Charleston.

(This nomination is seconded.)

(Motion was made that the nominations be closed—this motion was seconded and passed.)

The Chair: You will prepare your ballots for J. W. Chapman of Walterboro, and Robert Wilson, Jr., of Charleston.

The Chair would like to explain that these Councilors are elected for three years. Dr. Cain was not eligible having served for 9 years.

Dr. Cain: Dr. Cain was eligible, but he did not want to run again.

Dr. Van de Erve: Mr. President, I would like to state that I think the First District, District 1, owes a great debt of gratitude to Dr. Cain for the great work he has done during his Councilorship.

The Chair: Fourth District, the incumbent, Dr. J. B. Latimer.

Dr. Zeigler: Mr. President, we would like to re-nominate Dr. Latimer, we like him in that District and we would like to have him again. (This motion was seconded.)

Delegate: Motion is made that the nominations be closed and that Dr. J. B. Latimer be elected by acclamation. (This motion was seconded, the vote was taken and it was so ordered.)

The Chair: The Sixth District, this place will be vacated by Dr. McLeod, nominations are in order for the Sixth District.

Dr. Cain: I would like to nominate Dr. Howard Stokes of Florence. (This motion was seconded.)

Motion was also made that the nominations be closed, and duly seconded.

The Chair: You have heard the nomination of Dr. Howard Stokes of Florence and you have heard the motion that the nominations be closed. All in favor say "aye." (The vote was unanimous for Dr. Howard Stokes.) Dr. Stokes is elected Councilor for the Sixth District.

The Chair: The Seventh District is next.

Dr. W. J. Snyder, Sumter: I would like to nominate Dr. C. R. F. Baker to succeed himself.

Dr. Wilson: I would like to second the nomination of Dr. Baker and move that the nominations be closed and that the Secretary cast a unanimous ballot for Dr. Baker. (This motion was seconded.) The vote was taken and Dr. Baker was elected.

The Chair: The next is the Delegate to the House of Delegates to the American Medical Association.

Dr. L. E. Madden (of Columbia): I would like to re-nominate Dr. Tom Pitts,—he has served this organization well and has served as President of the

Association and as Delegate to the American Medical Association. I don't think we ought to change horses yet.

Dr. Weston: I second the nomination of Dr. Tom Pitts.

Dr. Gibbs: Gentlemen of the House of Delegates, without any prejudice against the man who has been elected and who has served so well, I want to place in nomination another man, a man who by reason of his long service on the Council and as Chairman of the Council a good many years, served this Association diligently and acceptably; a man who by reason of more than four years of service in the army is able to realize the problems of the returning medical officer, a man who by reason of his nice personality is able to win friends, a man who by reason of his independent thought can not be led around, he thinks for himself, and acts according; a man whom many of us love and all of us respect,—I wish to place in nomination Dr. Hugh Smith as Delegate to the A. M. A.

Dr. Goldsmith: I want to second the nomination of Dr. Smith.

Dr. Robert Wilson, Jr.: I should like to second the nomination of the man I think can best serve the Medical Association as delegate to A. M. A., and that is Dr. Hugh Smith of Greenville.

Dr. Hagnes: I move the nominations be closed. (This is seconded.)

Dr. Herlong: Mr. President and Gentlemen of the House of Delegates, there has been a good bit of dissension and confusion and we have several disgruntled members in our section around York County as to the retirement age in the State Medical Association. At one time, if you paid your dues for 30 years you became an honorary member. Some three or four years ago that rule was changed and it is now 40 years. I thought I would make a proposal and it could be brought before Council for consideration, that we make this age limit 65 years and when a man becomes 65 years of age he automatically becomes an honorary member of the South Carolina State Medical Association.

The Chair: Will the tellers give a report on the First District.

Dr. Smith: Chapman—43; Wilson—35.

The Chair: Dr. Chapman is elected Councilor for the First District. We will now hear a report of the last election, delegate to the A. M. A.

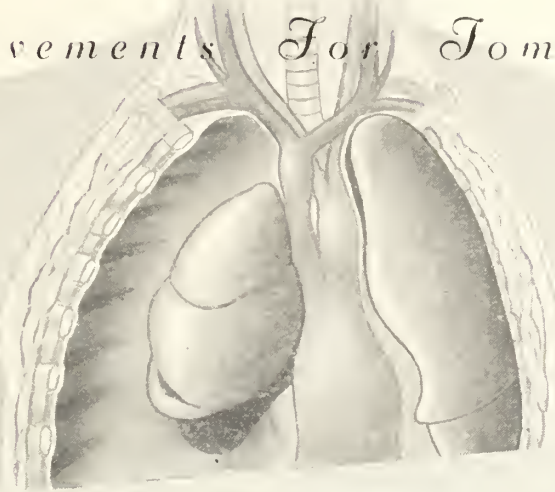
Major Smith: Mr. President, Pitts—36; Smith—45.

The Chair: Dr. Hugh Smith is declared elected a delegate to the American Medical Association.

The Chair will entertain a motion for adjournment. (This motion was made and seconded and the House of Delegates Ninety-Seventh Annual Session was adjourned.)



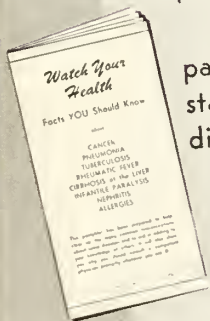
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* U. S. Summary of Vital Statistics, 1942.

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A Survey of The Medical College Expansion Program and Its Factual Background

By

Kenneth M. Lynch, Dean
John M. Boone, Assistant Dean
and
W. Atmar Smith

Francis G. Cain
William H. Kelley
Frederick E. Kredel
Pierre G. Jenkins

The Advisory Committee Foreword

This publication is intended to present briefly the story of the Medical College and its expansion program. It is designed to answer as many questions about the school and its program as is possible at the present stage of development. It is to be distributed widely before the people, the alumni of the Medical College, the medical profession of the State, the Legislature and State officials. We wish them all to have full first-hand knowledge of the Medical College's current status and of its needs, if it is to give the full service that is its purpose and obligation. At the same time we place responsibility upon them for action upon it, for it is to the advantage of the whole State. It constitutes a challenge which cannot be ignored.

As this description was being written, the end of the war and beginning of peace was announced. We of the Medical College have been very active in the past two years in trying to anticipate the conditions which are now immediately upon us. Our plans have suffered delay, partly because of war conditions themselves, but most importantly because of the rejection of enabling legislation by the South Carolina Senate in the last assembly.

In order that those, whose interest and responsibility demand that they be informed, shall have the full story of medical education in South Carolina, this publication is respectfully submitted. It is hoped that everyone receiving a copy will keep it at hand for reference as questions and discussions may develop.

HISTORICAL SKETCH OF THE MEDICAL COLLEGE

Early History

One hundred and twenty years ago the Medical College of South Carolina was begun under the sponsorship of the Medical Society of South Carolina (i. e. the Charleston County Medical Society), though responsibility for the venture was altogether

placed upon those elected to the Faculty. The original Medical College building on Queen and Franklin Streets was one of the handsomest of the early medical schools. It was abandoned when the school moved to its present site in 1914

Change of Name

In 1832, disagreement over election of the faculty between the Medical Society and the Faculty led to the latter's withdrawing to found a second school under the name of "Medical College of the State of South Carolina." However, harmony returned seven years later and the two schools were merged into one under the new name, which the school now bears. We have proposed that the school return to its original name as being both a more venerable and a shorter, handier title to use.

Period of Eminence

Following healing of the local profession rift in 1839, the school prospered and became renowned. During this period the Faculty participated in organizing the American Medical Association, a primary purpose of which was the improvement of medical education in this country. It was one of the first to advocate a full four-year medical course and to use actual patients in teaching. To sum up this period in the story of the College, it was an acknowledged leader in medical education and progress in America until the War between the States and financial ruin struck it down.

Post-Bellum Period

From its reopening after the War Between the States to the present day, the School never regained a leading position, but had a constantly recurring struggle to maintain an acceptable standing in comparison with other schools.

During the post-bellum period, medical education in America reached a low ebb. Medical schools multiplied, promoted and operated by physicians for private benefit. Many schools, we among them, were poorly equipped in personnel and facilities to apply

the benefits of scientific progress and improved teaching methods which had become available.

In the great reorganization and improvement of medical education in the early years of this century, the Medical College found itself facing the alternatives of closing its doors, or of finding sponsorship with sufficient resources to put it in acceptable condition and give assurance of continued adequate support. It was no longer possible for a medical school to operate on a satisfactory basis without large financial resources.

Period of State Ownership and Operation

In 1913 the realization of its importance to the State brought the crisis to a head. The school was given to South Carolina, and the State assumed ownership and responsibility for its support. The City of Charleston provided land, and public subscription, with faculty members being prominent contributors, built the first unit of the present plant. The State, the Federal Government, loyal alumni and individual benefactors have financed additions from time to time.

For maintenance the State appropriated in its first year of ownership a sum of \$10,000. This has been steadily increased until for the present fiscal year the State appropriation is \$286,328 in addition to tuition fees and a special planning fund.

The "Rating" of the College in Comparison to Others

In the period prior to State ownership, the school was rated by the American Medical Association in "Class C," which designated schools which were in the unsatisfactory, unapproved group. When the encouraging prospect of State ownership seemed likely, its rating was raised to "Class B," or the lower group of approved schools. After being taken over by the State, the curriculum was reorganized, full-time teachers were employed in the more important pre-clinical departments and sufficiently equipped laboratories for teaching were supplied. Then in 1916, the College was granted a "Class A" rating by the American Medical Association. In 1928, the American Medical Association dropped the A, B and C classification, and now ranks medical schools only as "approved" or "unapproved." Since then our medical college has remained on the Association's "approved" list.

This attainment is at the same time a credit and a responsibility. Position in medical school ranks is relative. It must be borne in mind that "approval" means no more than the possession at a time of inspection of *minimal* facilities for operation. It does not mean that one medical school on the approved list is as good as any other. What may be acceptable as minimal qualifications today may be unacceptable at any subsequent time. Medical schools are under continuous improvement, and this course is under remarkable acceleration at the present.

Complacency is a dangerous condition. This medical school, once a leader, has been in danger of having to close more than once since that happy era. It has steadily improved since the State adopted it, and it must continue to advance, at least in the pace of others, to exist. For more than eighty years it has been in a continuous struggle to meet minimal requirements. We are encouraged to believe that success of our plans would regain its place among the leaders. The opportunity must not be lost.

RELATIONS WITH ROPER HOSPITAL

For the greater part of its course the Medical College has traveled in companionship with Roper Hospital. For many years the faculty has served as the staff of the hospital, furnishing medical care to its charity patients and using its charity patients for teaching medical classes while giving this service.

Roper is owned and operated *in trust* by the local medical society. The *charge* in its trust is the medical care of the "pauper" sick of Charleston County, for which it also receives an annual appropriation from Charleston County. It also operates a private pay-patient department.

At the present, Roper is about to place in service a handsome new building for private patients, and ultimately hopes to complete an entirely new plant. Thus Roper also has an expansion program. What appeared publicly at one time as a conflict between the Medical College and Roper arose from the natural difficulties in the effort at fitting the two programs together. These difficulties have been resolved by a mutual agreement between the two institutions, issued as a joint statement on July 6, 1945. This statement was published in the Journal of the South Carolina Medical Association for August, 1945.

CLINICAL TEACHING FACILITIES OF ROPER HOSPITAL

Though in all teaching hospitals some use is made of private patients in the instruction of medical students, the great bulk of teaching material is furnished by the free and part-pay type of patients. The necessity of new clinical facilities for the Medical College arose from the inability of Charleston County, through Roper Hospital, to furnish sufficient teaching patients for classes of the size deemed necessary by the State Legislature, which controls the Medical College. There is no other community in South Carolina, for that matter, which has a large enough population to furnish these patients. Hence, it was felt that an institution which would draw general medical patients from the whole state would be necessary.

From an analysis of Roper Hospital's annual reports it is apparent that the maximum number of teaching patients to be expected is in no wise sufficient. The number of these patients during 1925 was 3085. It slowly increased to 4659 in 1939. Since

then it has steadily decreased to 3906 in 1944. For the scholastic year 1925-26, 39 patients per medical student were admitted. The number per student ran between 50 and 60 for the ten year period prior to 1942. During the past 2 years it has dropped to about 40 per student.

For comparison, the number of patients available per student in the ten *highest* ranking medical schools, according to the Council on Medical Education of the American Medical Association, in 1934-39 was between 103 and 251, or an average of 152. In the ten *lowest* ranking schools, the maximum patients per student was 92, the average 48. In other words, in teaching patients we were poorer than the average of the ten *lowest* rated medical schools, and had only one fourth of the average of the ten highest rated schools.

In the out-patient clinic the case is much the same. The number of new patients per year has steadily decreased from 6,414 in 1927 to 2,385 in 1944, or from 78 per student to 24.

ADDITIONAL CLINICAL TEACHING FACILITIES NECESSARY

Admittedly, the number of teaching patients is not the only requirement in clinical teaching facilities. However a sufficient number is basic, and the variety afforded by the "general hospital" type of clinic cannot be made up by any number of patients in the various types of "special hospitals."

In determining the number of teaching beds per student, we have studied conditions and expressions in this country and abroad. A British commission has recently recommended 10 hospital beds per student. In this country, ideas of those concerned in medical education have varied in recent times between three and five beds per student. We have arrived at the figure of five beds per student as satisfying the demand by approving agencies of "four *occupied* teaching beds to each student in the junior and senior classes."

Out of the consultations held between authorities of Roper Hospital and the Medical College the conclusion was reached that Roper could not guarantee any specified number of teaching beds, although it was desirous that the College should make use of whatever its facilities should prove to be. The number of "about 325 beds" to be furnished by the Medical College was estimated in these conferences to be necessary in addition to a possible three hundred to be furnished by the expanded Roper Hospital. Should both of these figures materialize, the 625 teaching beds would still be no excess according to present day requirements of teaching beds per junior and senior student.

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* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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IMPORTANT FEATURES IN THE OPERATION OF THE MEDICAL COLLEGE

Size of Classes

Provision of satisfactory facilities for classes *already enrolled*, rather than future increase, is the urgent objective of the expansion program. In 1944, we agreed to admit 60 students to the entering class, provided that the Legislature would expand our facilities to care adequately for that number. The understanding that additional clinical facilities would be provided by the time they became necessary gave birth to the expansion program. We were instructed in 1944 to appear before the next Assembly with our requirements. This was done, but as yet no provision has been made for the increased clinical facilities.

Legislators have urged us to admit at least 75 students each year. We have felt that this should be a maximum number, considering both the probable number of qualified applicants and the likelihood of having satisfactory facilities for training them.

We are quite familiar with the shortage of physicians in South Carolina, and are fully aware that it has an economic base with many angles, in the improvement of which the Medical College can have no direct function. Our position is simply that we are conversant with these conditions and have offered our participation toward their improvement. For whatever it is worth, more graduates will supply more doctors; but the quality of these doctors is dependent on the quality of applicants for medical education. That they may settle where needed requires more than merely that we shall train them.

Pre-Clinical Departments

It is customary to refer to studies in the first two years, which are largely spent in laboratories, as "Pre-clinical," as opposed to the last two "clinical" years, which are largely spent in the hospital and clinic in close contact with patients. We hope to develop cooperative group staff teaching to the point where there will be little demarkation between study in the scientific laboratories and in the wards and clinics.

The first use of the initial State appropriation in 1913 was in securing full time services of professional teachers in the laboratory departments. Since then, these departments have steadily improved until they now employ 38 full-time teachers, with the assistance of about 50 technicians and secretaries, as well as a fair complement of mechanical and ordinary helpers. The salaries of the professorships in these departments do not measure up to those of comparable positions in other schools, even of the less affluent, and badly need immediate elevation.

In general, we are not greatly concerned over the present staff and facilities in the first two years for classes of the present size. Most of the improvements in the school have gone into these departments. Additional needs, even for classes of 75 students, are relatively simple and not costly, though absolutely essential if classes are enlarged to this figure. Addition of one more full time teacher in each department, and completion of the quadrangle of College buildings would be enough. The latter could probably be done at a cost between \$100,000 and \$150,000. On the other hand, this would be futile without adequate provision for the last two clinical years.

Clinical Departments

It is in facilities and personnel for teaching in the last two years that the really abject deficiencies of the College now reside. Up to eight years ago the clinical courses, requiring the use of patients, were carried entirely by Charleston physicians, serving on a part-time voluntary basis, receiving only a modest honorarium for the incalculable sacrifices they made of their time and effort.

Although the faculty of the College was aware of the inadequate condition of the clinical staff, efforts to afford fulltime, professional *clinical* teachers were unavailing until surveys of the school by approving agencies in 1935 and 1940 forcibly called attention to the deficiency and helped to initiate a beginning in this direction. As had previously occurred in the pre-clinical departments, some full-time clinical teachers were taken from private practice and

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The part-time practitioner element of the clinical staff is still in service and will always remain indispensable in a school which attempts to train practitioners. But in comparison to other modern medical schools, our full-time clinical staff is badly in need of considerable enlargement without regard to any increase in class size or of number of patients under their care. With Roper's expansion this will be an additional requirement, while for the proposed Medical College-Hospital a large increase will be necessary.

The financial requirement for this expansion would not be excessive if the type of organization proposed is carried out. Otherwise, the expense would probably be too great to expect of the State under present conditions of population and wealth.

Library

The Medical College Library is one of the essential facilities. It has grown from nothing in 1913 to quite respectable status, and is very heavily used by faculty and students both day and night. It is badly located on the ground floor of a very noisy street corner. Its space, already overcrowded, cannot be enlarged in any feasible way in the present location. Apparently the only solution to this problem is to seek funds for a new and differently located building. The space for this opportunity is available if other land is provided for the clinic-hospital growth.

Living Quarters for Students

Since no living quarters of any kind are made available by the College to students, some thought has been given to construction of library and dormitories in one building and so making the library a part of the students' home. A dormitory could, of course, pay its own way. We invite alumni, students and those interested in the welfare of the medical students to give serious thought and assistance in this matter.

Post-Graduate Work

The utter lack of facilities for post-graduate study in any category has long been a handicap upon the school. It has become embarrassing at the present because of daily pleas from veteran doctors returning from military service, for assistance in regaining their civilian medical feet. The doctors of this state,

and particularly our alumni, should be able to return to us for such refreshing and continuation of their medical training as they may need. Instead, they have to go distances, at great inconvenience and expense, if they are to keep pace with medical progress and improve the service which they dispense. As a result, many make little effort in this way after their graduation.

It is one of the features of our expansion program that we shall have the opportunity to develop post-graduate training of physicians that they may better serve their communities. In the State are a number of other hospitals and medical institutes which could be fitted into a system of postgraduate work for special training. This is an undeveloped field, and a large and attractive one. It will be taken into account in integration with our whole plan.

Research

The war just concluded has changed the public regard for research from a hazy conception to one of great practical meaning. Everyone knows that the atomic bomb and radar were the products of pure and intense scientific research. Research in all fields, including medicine, has been given tremendous impetus.

It is not generally realized that this activity goes on constantly at the Medical College. Now and again the school has taken credit from the investigative effort of some faculty member. Usually, because of the great burden of routine duties, this must be done through quite unusual effort and intense urge within the individual.

To give opportunity to carry on research is part of the school's obligation to its faculty. Scientists require this opportunity where they accept position. Without the facilities and time required for this purpose, first class men cannot be attracted or retained here. Greater encouragement and more time for research into the unsolved problems of medicine are naturally part of our expansion plans. To be constantly searching for improvement in the well-being of humanity is part of the natural function of a medical school. Interwoven with such operations as we propose, it can and will take place with increased intensity and success.

THE PROPOSED CLINIC-HOSPITAL

Two Possible Plans

The foregoing paragraphs have pointed out why additional clinical facilities are needed for the medical classes, for postgraduate teaching and for research. Since no community in South Carolina is, or can be expected in a reasonable time to be, large enough to furnish this amount of teaching patients, an institution to supply them must draw patients from the entire State. Two types of institutions could fulfill the requirements.

First is a free State general hospital, built and maintained by State appropriations. There are a number of practical reasons why this type of institution would be unsatisfactory. Many communities in the State are already supplied with public general hospitals, and others are becoming so under the auspices of various agencies. A free State hospital would duplicate these community services, which are equipped to care for the great majority of patients near their homes. Further, a free State general hospital would inevitably become of large and unwieldy size, and since patients were free, would be unbearably expensive to maintain. Since patients could not readily be selected, many would be unsuitable for teaching and so defeat the purpose of the hospital. The salaries of the large medical staff required to care for these patients would add further to the load of maintenance.

The second plan which we have chosen as suitable for our purposes offers the solution of a great medical service need, and is possible to accomplish without heavy additional burden upon the State treasury. This plan has been followed in other medical centers and found workable and satisfactory. It contemplates no completely free service, but sufficient charges to patients to pay, at least the larger part of maintenance costs, and through professional fees charged those able to pay the salaries of the staff.

Cost of Operation

From a reasonable calculation, if as much as two dollars per day were lost on a third of the patients admitted, the financial demand upon the State for maintenance would be less than merely for staff salaries under the first plan. In fact, from a conservative estimate of the prospects in this state from the U. S. Public Health Service and other unprejudiced agencies, it appears possible that such an institution should be practically selfsupporting after full development and under proper organization and operation.

Admission of Patients

Patients would be admitted on referral by practicing physicians, and would not be able to come merely on their own volition. The physician would be considered a party in the case, receive reports from the clinic, and his wishes be considered in the course the patient pursued. This would prevent competition with private practitioners, and provide a center for working out and caring for cases which are now referred to distant centers, many of whom are unable at present to go long distances for such services.

The patient would be referred to the staff of the clinic, not to an individual member of the staff. After admission, each patient would naturally be assigned to the staff member considered by the staff as best qualified to care for that particular case.

Use of Patients for Teaching

All patients would be teaching patients; that is students, interns and residents would assist the staff doctors in serving them, and thereby learn. One must not mistake the present day system in such clinics for the outmoded procedures in teaching charity hospitals where patients were pulled and hauled in large class clinics. In the proposed organization, students and interns assist individual doctors, and in most instances patients are scarcely conscious of teaching procedure.

Fees to be Charged

All patients would be classified as to economic status by a social service operated by the clinic. Those judged unable to pay even full hospital cost would be given the same care as others at a below-cost charge, and receive professional service free. Those able to pay full hospital cost but no professional fee would be charged the regular per diem charge and receive professional service free. Those whose financial circumstances were judged sufficient would be charged the regular rate established by the hospital, and any surplus income from this class used to offset the deficit from the below-cost class.

Professional fees charged the third class would be in accord with average fee bills established by the medical societies of the State. A range of reasonable round fees for complete diagnostic surveys would be established rather than piece work charges. Any fear of unfair practices in relation to the private practice of medicine appears entirely unjustified. Such a clinic could not succeed without the support of the medical profession of the State.

Organization and Compensation of the Staff

The staff of the proposed college hospital will naturally be limited to the teaching physicians of the Faculty. The Faculty and Board of Trustees will establish the internal organization which will serve as an integrated unit. From the same Faculty organization, the charity service of Roper Hospital will be staffed.

The full-time and part-time members of the clinical staff will be employed on a *salary basis*, the salaries to be determined by the Board of Trustees. Professional fees collected from patients able to pay full-scale charges will be used toward payment of these salaries.

There should be one or more lower levels of salaries for members who are winning their spurs in experience and productive effort, and a higher level where men who have reached their prime and come into high position may be reasonably compensated for their accomplishments. It is agreed that *salaries* shall be adjusted at a level high enough to attract highly trained teachers, yet not so high as to tempt staff members to engage heavily in practice to the detri-

ment of their teaching and research. Such salaries will always remain below the levels which men of such attainments might expect in private practice. South Carolina is not accustomed to high salaries, and were it not that some of the most competent and desirable scientists and doctors prefer to do institutional work where they may continue study and research, we would not reasonably contemplate success in gathering and retaining the type of staff required.

Service as a State Medical Center

Although in a sense secondary to its educational purpose, such a medical center would provide a direct service now lacking to the people and physicians of the State. In the practice of medicine there is always a certain proportion of patients who require service beyond that which any individual physician may give, no matter how accomplished he may be. For many years our people have been referred in considerable numbers to various organized clinics outside the state. This is an inconvenient and expensive condition, and some of those who do go can ill afford it. Many who are in need of such service are not in position to secure it. These would furnish particularly the first two of our designated economic classes of patients.

We are not principally concerned about the well-to-do and the ne'er-do-well social classes. Generally they are provided with good medical and hospital service. We have in mind particularly the great middle class, comprising the largest and most important population element. We have no doubt of the availability of sufficient clientele; rather we believe that, on the basis of statistical estimates which may reasonably be made, our provisions will prove short of the demand. The presence of a highly organized medical center in the State should be of inestimable service to the practicing physicians of the State in working out problems of diagnosis and treatment for patients who are at present sent out of the State, if this service is to be obtained.

Implications Relating to Socialized Medicine

Medicine is already "socialized" to considerable extent, and the State will undoubtedly become more closely interested in various aspects of medicine. The important point is whether the proposed clinic-hospital might be a measure of *political* medicine. Of that we have no fear. It would have the same organization and control that the Medical College already has. No political agency will appoint the staff, none will select the patients.

How Radical a Departure is this Proposal?

By far the majority of the approved four year medical schools of this country actually own or absolutely control at least the major hospitals used by them. In more than half, the relationship is essentially ownership. In only about six is there merely a loose

affiliation comparable to ours with Roper. None of them are placed among the leaders.

Of the 8 schools heretofore offering only the first 2 years of the medical course, six are now in the course of expanding to own their own teaching hospitals and to offer a full four years. In fact, practically all of the medical schools in this country which are not already abundantly supplied are now in the process of expansion, and many of these programs are of much larger scope than ours.

Unless the Medical College shall be successful in its effort, it will again stand as a laggard and will be relatively reduced in its position among the medical schools of America.

Financial Considerations

Except possibly in its early period, when medical knowledge and equipment were small and called for only small treasuries, the financial condition of the Medical College has always been critical. The present time seems to be the opportunity of the lifetime of the school to provide for present and immediate future needs.

The value of the present plant and its equipment could hardly be estimated at less than one and a quarter million dollars. Duplication under present conditions would no doubt cost much more than that.

In our proposed construction program, it was estimated that the clinic-hospital, including quarters for nursing and resident staff, would cost \$2,925,000 while the necessary land might be obtained for about \$250,000. The College quadrangle could be completed for between \$100,000 and \$150,000. We have asked for a building appropriation from the State of about \$1,750,000 in anticipation that the Federal Government would match that amount.

This would not cover the cost of a badly needed library or of a students' dormitory. A longer time program is visualized and will be matured when the presently proposed foundation is established.

Capital outlay for the construction program is available to the State and is not beyond its means. Nor is it an exorbitant proposal by medical educational experience or by comparison with the programs of other states. We have a reasoned belief that the success of our plans will add a tremendous asset in the health and well-being of the people of our state, without unwise or burdensome initial cost, and without saddling the State with an expense which could be ill-afforded in slack economic times.

CONCLUSION

In conclusion, there have been presented here, so far as this brief publication will allow, the story of medical education in South Carolina, its accomplishments, its present condition, its purposes, plans and hopes. The faculty and the administration do not

propose to relax their efforts to provide for its continuing success.

At the same time, they cannot accomplish this alone. As they did in 1823 and again in 1913, they place before the government and the people of the State the requirements, the circumstances and factors

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NOVEMBER, 1945

MEDICAL COLLEGE EXPANSION

At the recent meeting of the House of Delegates a comprehensive survey of the proposed medical college expansion was presented. This was received as information, and Council was instructed to appoint a committee to study the survey and to bring back its report with such recommendations as might be indicated, to the House of Delegates at a call meeting before the 31st of December, 1945. The committee was to consist of one member of the Association from each Judicial Circuit of the state (14 in all), the President and Secretary of the Association as ex-officio members, and the Director of Public Relations as executive secretary and counsel.

The Committee was appointed and met for its first time in Columbia on October 12. Under the chairmanship of Dr. James McLeod, the Committee discussed the work and made plans for the future.

It was felt that the first step was to study the present facilities of the Medical College and to discuss the whole program with the Dean and Board of Trustees of the school. So the Committee decided to spend a day in Charleston for this purpose at a date suitable to all parties concerned. At this writing the date has been set for November 16.

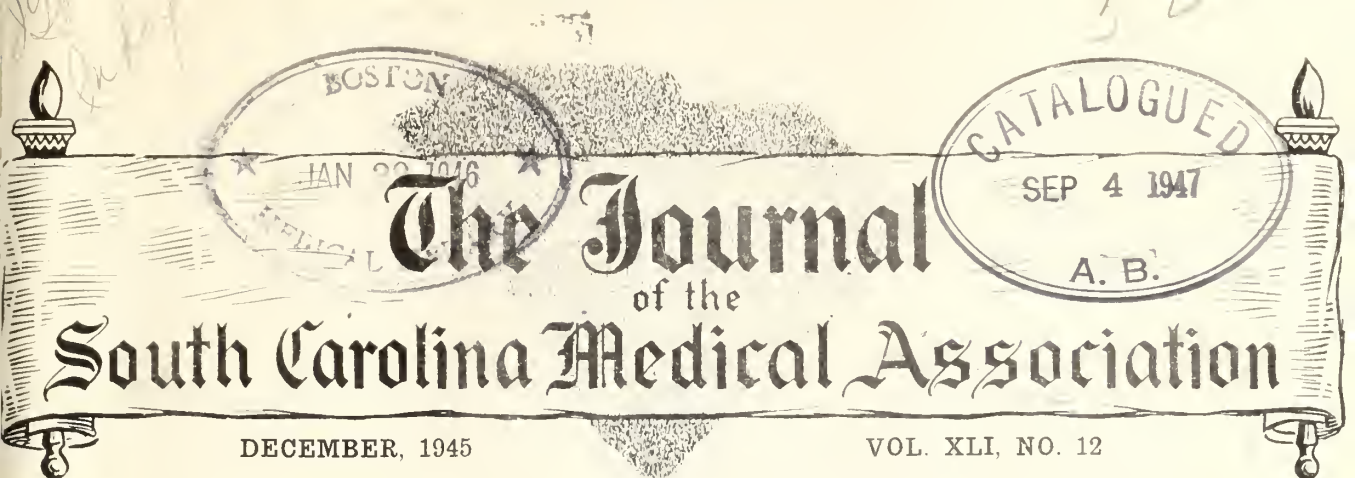
Another matter which provoked considerable discussion was a request from Senator Berry for a hearing before the committee of the Richland County delegation. Senator Berry had read the account of the appointment of the Committee in the press. The Committee felt that one of its functions was to gather all facts relative to the expansion of the Medical College and to hear the views of those—be they county delegations, organized groups, or individuals—who were concerned with the work and development of the Medical College. The Committee therefore, is planning to meet in Columbia on November 20 to hear the discussion presented by the Richland County Delegation.

Following these two meetings, and such other meetings as may be necessary, the Committee proposes to lay all the facts before the members of the

Association through district and county meetings and through personal contact. After ample time has been allowed for study and discussion, the House of Delegates will be called into session and the Committee will make its formal report with such recommendations as it may desire.

In our opinion, the Committee is going about its appointed work in a logical and efficient manner. The Committee, representing the S. C. Medical Association, is attempting to use what might be called the "medical approach." The patient—the Medical College—has been presented for diagnosis and treatment. The family and past history and the present illness—the Survey (printed elsewhere in this issue)—has been presented. As any medical student knows, the next procedure is that of the physical examination—and this will be carried out when the Committee holds its meeting in Charleston. Following this comes the assembling of the reports from various laboratory procedures—and this will consist of the reports of the Board of Trustees and of the Dean, and the discussions and suggestions made by other interested groups or individuals, and also through such additional studies as the Committee may desire to make. Having assembled all the facts, the Committee will then ask for consultation—this will be obtained through discussions in district and county societies and through individual conversations. Finally, comes the clinic—the call meeting of the House of Delegates—with full and free discussion with all facts at hand. The final diagnosis and outline of the course of treatment will be up to the highest authority in our Association—the House of Delegates.

We are convinced that the method of procedure adopted by this Committee will work toward the best interests of the Association and of the people of South Carolina. The citizens of South Carolina will be given the benefit of the careful study and seasoned judgment of a group of men who have been trained to think along scientific lines. The Association will be afforded the opportunity of leading the state in matters pertaining to medical education, and will be in a strong position to present a course of action for consideration by the General Assembly at its next session.



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The Hazards of Bed Rest

WALTER R. MEAD, M.D., FLORENCE, S. C.

The fact that there are certain hazards connected with bed rest is a matter of common observation in the practice of any physician. We are all aware that elderly patients tolerate recumbency poorly and that broncho-pneumonia and profound debility develop with great rapidity when it becomes necessary to put an aged individual to bed. Another instance is noted in the case of those fairly healthy individuals who are put to bed for a rest cure. In a great many cases of this sort the cure is much worse than the disease. Many of these patients become confirmed invalids from the time they are put to bed. Still a third example is the patient with nocturnal cardiac dyspnoea. These individuals, usually suffering from hypertension, coronary or aortic valvular disease, go to bed in a fair state of comfort but waken around two or three a. m. desperately short of breath and unable to lie in bed an instant longer. Their hearts were fairly well compensated when they went to bed but a few hours of recumbency have resulted in active decompensation.

Not only is it a common experience that bed rest sometimes gets us into trouble, but it is an equally common experience that unpremeditated physical activity during a time when complete bed rest is considered essential does not result as we might anticipate. Take for instance the case of the young child whom we desire to keep quiet because of a surgical or medical illness. It is practically a physical impossibility to keep these youngsters flat on their backs or even on the bed for that matter but the rate of recovery from illness and operation without complication is higher in this age group than with adults. Also, take the example of the post-operative patient who is mildly delirious and gets out of bed on the day after an operation when no nurse or attendant is immediately available to curb his activities with another dose of morphine. We commonly express amazement when such patient makes a fairly uneventful recovery afterward but so far as I know

very few of us have been willing to deduce from such experiences that possibly this untoward activity contributed to his recovery rather than retarded it.

Such experiences as the foregoing should at least leave us with an open mind for such a suggestion as the one by Dock¹ that "the physician must always consider complete bed rest as a highly unphysiologic and definitely hazardous form of therapy, to be ordered only for specific indications and discontinued as early as possible."

Of course there are varying kinds of bed rest. Even a prolonged period of bed rest for lively young subjects who receive no narcotics or sedatives will have few harmful results. On the other hand most of the worst results, often fatal results, occur when indolent, obese patients are confined to bed after anesthesia or after sudden onset of cardiac symptoms, and with enough discomfort to justify the continued use of either hypnotics or narcotics. They lie on their backs, possibly propped up in the Fowler posture. This is an unusual position and one which they would almost never assume under normal conditions when they expect to rest. Because the position is unusual, they have difficulty going to sleep, so sedatives are given, or possibly a dose of morphine. The net result is several hours of inert recumbency marked by shallow breathing and complete muscular inactivity.

The evil effects of such type of bed rest are best seen in connection with the cardio-vascular system. Heading the list of such hazards is thrombus formation in the leg veins and its ever present threat of pulmonary embolism. This is especially true of cardiac patients where immobility of the legs and abdominal distension with its pressure on the iliac veins aggravates an already pathologically slow blood flow through the legs. The orthopnoea which many of these patients exhibit when first seen adds still another factor — flexion at the hips means still further

pressure on the leg veins in the groin.

But not only cardiac patients are subject to thrombus formation in the leg veins. It is extremely common in the period of post-operative recumbency which is usually rigidly enforced by most surgeons. Dock¹ believes that in these otherwise healthy patients, the pressure of the lower legs against the bed may be an important cause for thrombus formation. Certainly it is a common finding with all of us that phlebothrombosis starts in the gastrocnemius muscle group. At any rate, pulmonary embolism which may readily follow thrombus formation in the leg veins of either cardiac or post-operative patient is always a serious situation and may prove fatal.

In cardiac patients we are too prone to incriminate the right side of the heart when fatal pulmonary embolism occurs; this more or less absolves us of blame for the tragedy because after all we cannot be held responsible when some intracardiac thrombus decides to cast off and float along the blood stream into the lung. As a matter of fact careful search of the veins of the leg or pelvis will reveal the great frequency of thrombosis there which is the true source of the pulmonary embolus. At such a site, the thrombus is a very real responsibility of the physician. The breaking loose of these clots occurs during a sudden rise in venous pressure as in coughing, deep breathing, getting out of bed, or "bearing down." It is considered quite possible that a great many very small clots are separated from their points of attachment by one or more of the above forms of exercise. These small emboli find lodgement in the lungs but their minute size produces no reaction. The danger comes when the small clots are allowed to become really sizeable by discouragement of all forms of activity during bed rest. When these break loose and rush to the lungs, we are in for serious trouble.

Another reason that bed rest is often attended by unpleasant results in the case of cardiac patients is because bed rest does not always mean lessening the work of the heart; in fact it often means increasing the circulatory load, both directly and indirectly. It is important to remember that there are two sides of the heart, normally working in perfect balance. If the right ventricle expels one drop of blood less than the left ventricle at each beat, in a very short time venous pressure will rise and there will be definite engorgement of the liver. And, also, if the right ventricle expels one drop more than the left ventricle there will result severe pulmonary edema in a short time. Now when we put the cardiac patient to bed, by elevating his lower extremities we are immediately increasing venous return to the heart, as well as encouraging dependent tissue edema to drain into the venous bed. Both of these factors increase the work of the right side of the heart. The left side, already diseased, then finds it difficult to keep up with the increased output of the right side, and pulmonary congestion develops. This is the logical explanation

for the development of attacks of nocturnal dyspnoea in those cardiac patients who manage to keep going throughout the day without signs of circulatory embarrassment.

The disappearance of dependent edema which follows recumbency in decompensated cardiac cases frequently indicates merely a shift of fluid from the lower to the higher portions of the body; not infrequently such a patient will develop a large pleural effusion shortly after going to bed indicating that the engorgement has shifted from the systemic to the pulmonary circulation. This hydrothorax in turn increases the patient's dyspnoea and the constant struggle for breath taxes the laboring heart still further.

I do not mean to imply that every time we put a decompensated cardiac patient to bed we are doing him harm. Fortunately the act of putting him to bed is usually only one of a series of procedures such as institution of digitalis therapy, employment of mercurial diuretics, et cetera, all of which serve to more than counter-balance some of the deleterious effects of sudden complete recumbency. I do wish to imply that many times we might make faster progress with our therapy if we were not so insistent on early complete recumbency. And while we are on the subject of circulatory troubles incidental to recumbency some mention should be made of the use of the bedpan. To mount a cardiac patient on one of those torture instruments after he has been perfectly quiet for several hours, probably badly constipated from narcotics and utter immobility, and to let him strain and "bear down" to secure a bowel movement in a most uncomfortable and unphysiological position, is certainly an invitation to disaster. The disaster which is invited is pulmonary embolism or possible rupture of the heart which has had recent myocardial infarction. Such possibilities are very real and as a rule there is no good reason to subject a patient to such risks; it is much safer for the patient to use a commode.

The psychological aspects of bed rest need some passing consideration also. The bedfast patient finds himself in a wholly new and for some, delightful environment. He suddenly finds that his well-being is so important that doctors, nurses, orderlies and visitors compete to look after his slightest wants. His ego is tickled. No matter how much he may have been pushed around before in his home or in his business, in bed, as a patient, he is on top of the world. For many the experience of being sick in bed is an unforgettable one. They learn for one thing that such illness provides refuge from the anonymity of their former daily existence. They become familiar with the terminology of sickness and conscious of the privileges which illness confers. Often they develop an unhealthy preoccupation with symptoms. It takes a particularly sane and well balanced individual to withstand the insidious influence which tends to change the personality of one who is the center of

the stage in a long illness.

The so-called rest cure is an especially hazardous treatment to advise. Ever since Weir Mitchell popularized this form of therapy during the latter part of the last century, it has been used quite widely with certain modifications in minor physical and psychological disorders. In minor physical disorders it has the unfavorable effect previously mentioned of focusing the patient's attention on trivial symptoms resulting in an exaggerated idea of the importance of his illness. When used as Mitchell advocated for "nervous breakdowns" and "nervous exhaustion" and the neuroses generally, the rest cure has the additional disadvantage of being futile. Misdirected energy rather than inadequate energy lies at the bottom of neuroses and psychoses and other maladjustments. Menninger² illustrates the point by stating that an automobile whose engine has become overheated as the result of being driven with the brakes set, cannot be made to perform successfully simply by drawing up at the side of the road and stopping. If traveling is resumed, the engine will again overheat unless the brakes have been released in the meanwhile. The maladjusted person has his brakes locked so that he performs his daily tasks only under great handicap with increasing inefficiency, pain and internal and external dissatisfaction. It is absurd to conclude that merely popping such a patient into bed is going to remove the blockage of energy which finally became so great that he had to seek help.

There is very little proof that rest in bed carried out for many weeks after symptoms have disappeared is of value in the physical management of a patient with congestive failure, angina pectoris or myocardial infarction. There is a great deal of evidence that such treatment results in an alarming increase in the number of persons suffering from a cardiac neurosis. Harrison³ points out that once an individual has recovered from the initial phases of his cardiac attack, the normal desire to resume activity occurs and each additional week of complete rest can be achieved only at the expense of increased urgency on the part of the physician. Such anxiety is readily transferred to the patient so that he enters a state of psychic invalidism characterized by constant apprehension. He dies a thousand deaths and it is not pleasant to think that we, as his advisers, are responsible for his unhappiness.

Time does not permit an adequate description of all the hazards of prolonged bed rest. Such a description would include atrophy of muscles, joint structures and bone which are particularly significant to the orthopedist and to the doctor who treats much arthritis. It would also include urinary retention from an atonic bladder and the development of prostatic obstruction leading to uremia; plenty of us have seen the onset of obstructive uropathy on confining elderly men to bed. To be complete we should also mention

constipation, cathartic habituation, and chronic lumbosacral backache among the unpleasant sequelae of the type of bed rest we have been discussing.

At any rate, sufficient evidence has been presented to suggest that there are very definite physical and psychological disadvantages to prolonged bed rest. If that viewpoint is tenable, it would be well for us to reconsider and possibly modify our methods in the treatment of those conditions where complete inactivity in bed is ordinarily considered the sine qua non of adequate care. I refer specifically to the immediate post-operative surgical patients, the acute and chronic cardiac patients, and those patients with acute and chronic febrile medical disease.

Powers⁴ has recently presented rather dramatic proof that prompt post-operative activity such as walking not only has no bad results but reduces the incidence of pulmonary complications (pneumonia and atelectasis) by seventy-five percent, minimizes the development of thrombosis in the legs, diminishes the possibility of post-operative dysfunction of the gastro-intestinal tract, possibly speeds up the healing of the wound and most certainly improves the morale of the patient by removing the fear of those factors which the layman most dreads in connection with a surgical operation — the "gas pains," the enemas, the bed pans and the hypodermics. Powers' patients were made ambulatory on the first post-operative day. In addition to getting up out of bed and walking, they were encouraged to take active muscular exercise in bed and do considerable deep breathing.

As for the cardiac patients, it is probably well to think twice before we insist on complete bed rest for the ones with congestive failure. Levine⁵ suggests that many should not be kept flat in bed until active cardiac treatment has advanced to the point where the circulation has improved sufficiently to withstand the possible deleterious effects of shifting fluid from the legs to the lungs. He advocates having such patients sit up in a chair for a good share of the time during the first days, exercise their legs and take short walks in the room. And when they are in bed, the bed should slant downward from the head to the foot, not jack-knife in the middle as do most hospital beds. And to prevent thrombus formation in the leg veins, it is well in these, as in all bed patients, to urge both active and passive movements of the legs. The "bicycle riding" exercise in bed is admirable for this purpose and also fairly vigorous daily massage of the legs.

The cardiac patient suffering from recent infarction requires a little more individualized judgment. The severity of the initial attack as well as the evidence of progress in healing indicated by such indices as fever, leukocytosis and sedimentation time will determine the desirability of resumption of any activity. Even in those cases with severe infarction, the recumbent position need not be enforced if they

are more comfortable sitting. Complete inactivity probably should not be prescribed for a longer period than two or three weeks after the more acute and alarming symptoms have subsided.

I am not familiar with any literature dealing with the relative merits of complete rest in contradistinction to merely restricted activity in the treatment of ordinary acute and chronic febrile medical conditions. I have good reason to suspect, however, that an awful lot of time is wasted by a very great number of patients who are advised to go to bed merely because they have a degree or so of fever. It is so easy to tell a patient to "go to bed until forty-eight hours after your temperature is normal." Perhaps in these medical conditions we have been following the

advice of the advocates of bed rest too blindly. It would be well to have an open mind on the matter.

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Unilateral Agenesis of the Kidney with Double Kidney and Uretrocele on the Opposite Side and Genital Anomalies

MORDECAI NACHMAN, GREENVILLE, S. C.

This case is reported because, in the literature available, it is unique. Quite a few cases of congenital solitary kidney have been reported. The major portion of these seem to have been solitary, ectopic kidneys, largely in the true pelvis. Such cases are reported by Nicol (1), Goldberg and Fowler (2), and many others; McCrea (3) collected thirty-five such cases and reviewed the literature on the subject. Gibson (4) reports a congenitally absent left kidney in a boy of six, with a giant left hydroureter. The right kidney was normal. O'Connor (5) reported two cases having a congenitally absent kidney with an accompanying ureterocele on the opposite side, concomitant with hypertension. He emphasized the fact that following dilatation of the ureteral orifice, the hypertension subsided. This finding coincides with this case. The kidney present in his cases was otherwise normal.

Schumaker (6) reviewed the literature on the coincidence of renal and genital anomalies, and reported three cases of his own. None of the cases found in this and other reports, showed the absence of the kidney on one side, with a double kidney on the other, combined with a uterocoele and hypertension.

The patient, Mrs. N. D., a white female housewife, age 47, was admitted to St. Francis Hospital the 21st of June, 1942. Her complaints at that time were of persistent pain in the right side, dysuria,

occasional episodes of nausea and vomiting, and headaches.

The onset of her menses was thought to have been at eleven, as she began at this time to have severe cramping pains in her lower abdomen, regularly, but without showing any flow. This became so severe that she was subjected to laparotomy at 13. A bicornuate uterus, fully developed except for an atretic lower segment was found. Hysterectomy relieved her monthly pain, but left her with some right-sided distress.

The family history was negative except for the fact that her father died of hypertension and cardiac failure.

Physical examination revealed a well-developed and nourished white female. Blood pressure was 160/90. Heart and chest otherwise showed no pathology. She was quite tender in the right flank, and slightly so in the left. Kidneys were not palpable on either side.

Laboratory reports gave an acid urine, containing neither sugar, albumin nor casts. Some urate crystals were present. White count was 12,500, differential showed 62% polymorphonuclear leukocytes, 38% lymphocytes. Read count 4,550,000, hemoglobin 90%. Blood N. P. N. 30 mg. per 100 cc of serum. Blood Kahn and Wasserman negative.

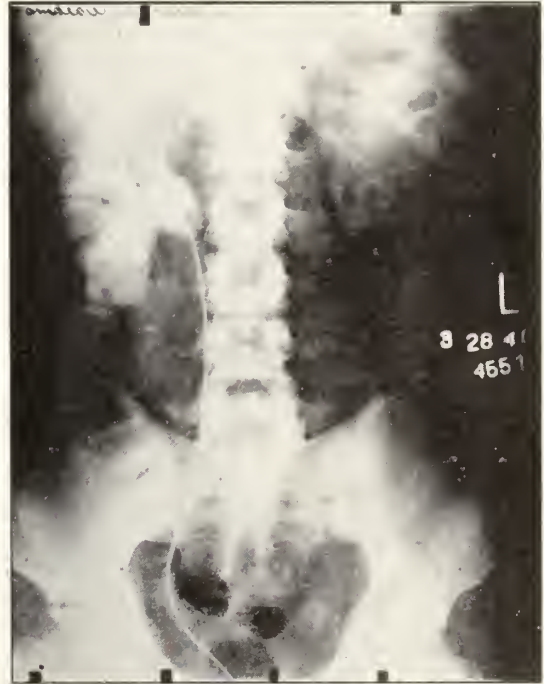
Excretory urogram showed a double pelvis and calyces on the right side, with separate ureters and

a ureterocele at the entrance to the bladder. No filling nor kidney shadow was noted on the left. The pain of which she had been complaining was observed to occur simultaneously with filling of the ureterocele, and diminished when it finally emptied its contents into the bladder. No calculi were seen.

Retrograde pyelogram (fig.) demonstrated es-

orifice could be found, and the left half of the trigone was absent. An excretory urogram showed a poorly filled right pelvis, with no shadow on the left side.

A ureterolithotomy was done, from which an uneventful recovery was made. Following his discharge the patient was seen at regular intervals, during which time his kidney function, as measured by phenolsul-



entially the same findings, showing a double kidney with separate pelves and ureters on the right side. The ureterocele was of the ureter from the upper kidney and possessed a pinpoint orifice into the bladder. No ureteral orifice could be found on the left side, and the left side of the trigone was missing.

Indigo carmine given intravenously appeared in 2 1/2 minutes, a normal concentration. The ureterocele was opened wide with cystoscopic scissors and the edges fulgurated with the high frequency current. The patient was discharged from the hospital on the third day in good condition. To date she has had no return of her pain and her blood pressure is 135/80.

This case of an unilateral agenesis of a kidney is added here because it shows several unusual features.

The patient, Mr. R. W., a white male, salesman, age 37, was first seen the 28th of February, 1936, complaining of generalized malaise, and hematuria. A preliminary scout plate of the abdomen revealed a radiopaque shadow in the region of the right lower ureter. Cystoscopy was done, and a large, impacted stone was found in the right ureter, beyond which it was impossible to pass a catheter. No left ureteral

fonphthalein excretion was normal, and his urine remained clear of infection. Repeated excretory urograms showed a normal right kidney, but no left kidney.

In 1939 he consulted a dermatologist regarding an eczema of recent onset. He was put on a markedly alkaline diet, and was instructed to take large quantities of citrus fruits and juices. On March 28, 1940, he returned with pyuria. X-ray (fig.) at that time revealed a large stag-horn stone of the right kidney. The urine was alkaline, full of pus and alkaline phosphates. The P. S. P. excretion was 12% in an hour.

In spite of acid ash diet and medication, it remained thereafter impossible to turn his urine to the acid side, or to clear it of pus. In spite of this, he went about his business as a salesman, and lead a normal life until May 1, 1942.

At that time he complained of nausea, vomiting, general malaise, headaches, and dizziness on slight exertion. NPN at that time was 160 mgm. percent. Creatinine was 4 mgm. percent. Bed rest and supportive therapy were instituted. On May 8, 1942 his

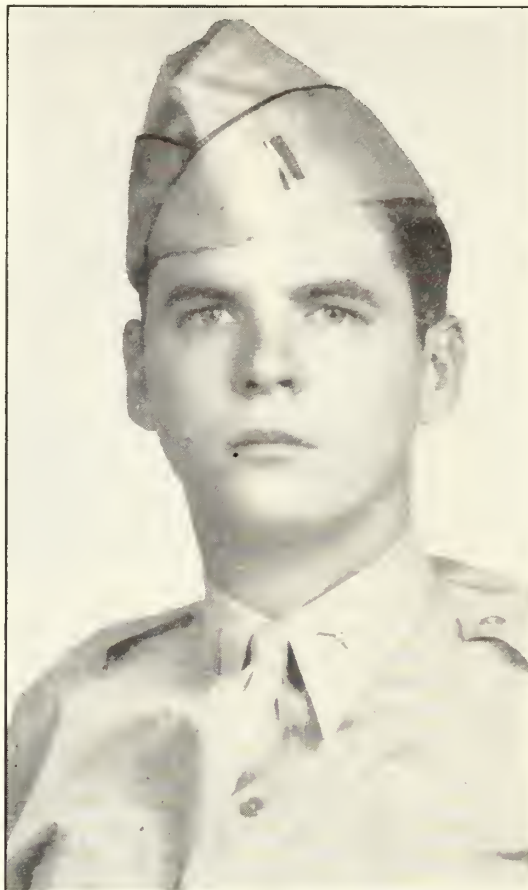
NPN had risen to 214 mgm. % and the creatinine to 6. On the 11th his NPN was 390 mgm. At all times he was mentally alert, and was sitting listening to a news broadcast when he died suddenly on the 12th of May. Autopsy confirmed the anatomical findings presented here.

This is presented as another case of unilateral agenesis of the kidney, which has the added feature of showing the rapidity of stone formation under certain conditions; the extremely high NPN without coma or convulsions is to be noted.

I should like to acknowledge the assistance of Dr.

Harwell Davis in preparing these reports.

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Captain Manning L. Nelson, Jr., was born in North, S. C., on April 19, 1917. He was graduated from the North High School in 1934, from The Citadel in 1938, and from the Medical College in 1942. He was a member of the Phi-Chi Fraternity. After interning at the Columbia Hospital, in June, 1943 he was ordered to Carlisle Barracks where he took his Medical Field training. Upon graduation there, he was ordered to Dallas, Texas, for assignment and after serving at Camp Polk, Louisiana, and Fort Blior, Texas, was sent overseas in October, 1943 and assigned to the 137th Station Hospital on Guadalcanal where he served for sixteen months. From

there he was transferred to the 305th Field Artillery (77th Division) as Battalion Surgeon and was sent to the Philippines and to the Ryukyu Islands where he was killed on Kerama Retto, an island twenty miles west of Okinawa, on a voluntary mission on March 28.

Captain Nelson was the only child of Dr. and Mrs. M. L. Nelson. His father was graduated at the Medical College in 1909 and has been practicing at North, in Orangeburg county, for nearly thirty-six years. He had married Miss Elizabeth Howell of Ridgeway, S. C., a few weeks before leaving for overseas. He was posthumously awarded the Purple Heart.

The Journal of the South Carolina Medical Association

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DECEMBER, 1945

The annual meeting of the South Carolina Medical Association will be held in Greenville on April 30, May 1 and 2, 1946.

Convention Headquarters — Poinsett Hotel.

DR. JAMES WILKINSON JERVEY, SR.

In the death of Dr. James Wilkinson Jervcy, on November 1, 1945, the South Carolina Medical Association has lost one of its most distinguished members. He had always been an active member and had served his State Association loyally and well in many capacities and on many occasions. He was interested in scientific medicine and in various associations founded for the study and advancement of his profession. That his ability and personal charm were recognized widely is attested by the large number of high offices he held in scientific organizations.

Dr. Jervcy was born in Charleston, S. C., on October 19, 1874. He attended the University of South Carolina and then the Medical College of South Carolina, receiving his M.D. degree in 1897. From the beginning of his medical career, he was interested in E. E. N. T. His first graduate work was in this field and at the New York Eye Infirmary. He located in Greenville, S. C., in 1898, and continued his private practice there throughout his life.

He did graduate study in Europe in 1908 and again in 1913.

Dr. Jervcy was a Diplomate of the American Board of Ophthalmology and of the American Board of Otology and Laryngology.

He was a member of the South Carolina Medical Association and served as its President in 1912-1913. He was President of the American Laryngo-Rhinological Association in 1933-1934, and President of the Southern Medical Association in 1937-1938. He served as Secretary-Editor of the South Carolina Medical Association Journal in its younger days. His willingness to serve his fellow physicians is perhaps most fittingly illustrated by his Editorship of the

Greenville County Medical Bulletin in recent years. This relatively minor position he assumed willingly during this last war when many of the younger and more active members were away in military service. He gave up this job only three months before his death and only because of his rapidly failing health.

He is survived by his son, Dr. J. W. Jervcy, Jr., of Greenville, S. C., a daughter, Mrs. Addison Ingle, of Charleston, and his wife, Mrs. J. W. Jervcy, Sr., of Greenville.

An individualist and a man of many interests who believed in and worked for the Medical Profession, Dr. Jervcy will be long remembered and missed by his many friends.

H. S.

WHOSE FAULT IS IT?

If all the members of our Association agree upon a course of action and work wholeheartedly toward its achievement, there is little chance for failure.

The above statement is not presented as a boast but as a simple statement of our personal belief. And we base our belief upon the grounds that the members of our Association, by and large, possess the four fundamentals of real leadership — intelligence, courage, tact, and integrity.

The very fact that a man is a physician implies intelligence—for what man lacking intelligence could pass the difficult examinations of college, medical school, and state board of medical examiners. To this is added the intelligence that accumulates from the everyday practice of medicine, the constant contact with people in all walks of life, the necessity for meeting and solving problems that are a part of every physician's work. Finally, we have the intelligence that comes from reading and from scientific study which is a part of a physician's life.

As we have seen them, physicians possess courage. We do not refer to the sudden exhibition of courage which receives popular acclaim, but rather to the quiet unassuming type of courage which makes one willing to stand by his convictions, come what may.

Tact is an integral part of a physician's armamentarium. He may have acquired it early in life or he may have learned it through painful experience, but possess it he must if his professional work is to be successful. The physician without tact is the physician with few loyal patients.

Few men are trusted as are physicians. We marvel more each day at the faith which patients have in doctors of medicine as they entrust their physical welfare or the welfare of their loved ones to the physician's care. To persist, such faith must be based upon integrity in the one who is trusted.

Intelligence, Courage, Tact, and Integrity — these are the foundation stones of true leadership, and these the average physician possesses. If the physician, so endowed, is not a leader in his community and if our Association, whose members are so endowed, is not a leader in the affairs of the state—whose fault is it?

WHERE SHALL THEY BE BUILT?

It is our sincere conviction that the next five years will see the beginning of a great hospital building program in this state. There is little doubt that Federal funds will soon be available for aid in building such institutions.

Studies presented in this Journal and in various other publications have shown the need for more hospital beds in this state. Estimates indicate that present facilities should be increased from 50 to 100 percent if our people are to be cared for adequately.

Before any program of hospital building is instituted, a thorough study must be made and a well formulated plan of expansion adopted. The Association should assume an important role in making this blueprint of the future, and this we hope to do.

The Permanent Committee on Hospitals, authorized by our House of Delegates, has been appointed, as follows:

Dr. Jack Parker, Greenville—Chairman
 Dr. W. A. Smith, Charleston
 Dr. Ben Wyman, Columbia
 Dr. V. P. Patterson, Chester
 Dr. W. R. Tuten, Fairfax.

Any member of the Association who has suggestions to make regarding a hospital building program should send them to Dr. Jack Parker, Chairman, Greenville, S. C., or to Mr. M. L. Meadors, Executive Secretary, Florence, S. C.

The Ten Point Program

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

THE PRESIDENT'S NATIONAL HEALTH PROGRAM

On November 19th the President of the United States transmitted to Congress his message requesting legislation to provide for a National Health Program. On the same day the Bill to implement the President's proposal was introduced in the Senate (S. 1606) by Senator Wagner, for himself and Senator Murray, and simultaneously in the House of Representatives (H. R. 4730) by Mr. Dingell. In his message, the President pointed out five basic health problems, and to meet these, suggested a comprehensive and modern program likewise consisting of five parts.

Stating that in the past the benefits of modern medical science have not been enjoyed with any degree of equality, Mr. Truman continued: "Nor are they today. Nor will they be in the future—unless Government is bold enough to do something about it." Referring to the returning medical officers, he said "Demobilized doctors cannot be assigned. They must be attracted, they must be able to see ahead of them professional opportunities and economic assurances." He believes that these are offered by his program.

Other expressions contained in the President's message were these: "The principal reason why people do not receive the care they need is that they cannot

afford to pay for it on an individual basis at the time they need it. This is true not only for needy persons. It is also true for a large proportion of normally self-supporting persons."

"The States, localities, and the Federal Government should share in the financial responsibilities."

"The general policy of Federal-State partnership which has done so much to provide the magnificent highways of the United States can be adapted to the construction of hospitals in the communities which need them."

"The emergency maternity and infant-care program for the wives and infants of servicemen—a great wartime service authorized by the Congress—has materially increased the experience of every State health agency, and has provided much needed care."

"The Federal government should cooperate by more generous grants to the States than are provided under present laws for public health services and for maternal and child health care."

The President recommended "solving the basic problem by distributing the costs through expansion of our existing compulsory social insurance system." This, he maintains "is not socialized medicine."

We have read carefully the President's message. It contains many expressions which are entitled to

serious, thoughtful consideration. Others will provoke only controversy. We have also read carefully the speech by Senator Wagner upon his introduction of the bill. The measure itself has just come to our desk, and we have had time only to scan it hurriedly.

From this brief perusal and from the remarks of Senator Wagner, the bill appears to be a combination of the health provisions of the "Social Security Amendments of 1945," (the second Wagner-Murray-Dingell Bill), the provisions for increase of grants for certain Public Health Services included in the same measure, the recent all-inclusive EMIC bill, and an added provision for medical care for Needy Persons.

There is one important difference between this and previous Wagner-Murray-Dingell bills, however. This bill omits the troublesome and obnoxious reference to taxation, euphemistically termed "contributions" in a former bill, and payroll deductions. It contains only provision for the benefits—none for the costs. The disagreeable idea of an increase in the social security tax to take care of the expense is omitted. Only the attractive features remain. The bill is therefore much more apt to receive favorable consideration, and is, in our opinion, a more dangerous form of legislation. If this huge burden is to be added to the government's present severe load, there should be at least an effort to fairly provide for the additional cost. The people should know what their new security will cost—in dollars, if not in finer values.

This, we believe, is "it." The maneuvers, the feints, the diverting actions have been carried out. This marks the beginning of the real campaign which will be fought with increasing vigor and determination in a supreme effort to establish socialized medicine in the United States.

Nor can the medical profession any longer fight a delaying action. It is high time that it face the facts, marshal its forces and prepare an effective counter-attack, or else assume an active role in negotiations for an "honorable peace."

PUBLIC RELATIONS CONFERENCE

One of our first official acts since receiving our new title, Director of Public Relations, was to attend a public relations conference, sponsored by the Council on Medical Service and Public Relations of the AMA in Chicago. Your President-elect took advantage of this opportunity likewise, to become familiar at the source, with the thought and efforts being made toward improvement of public relations of the profession. The meeting was highly profitable and a very pleasant trip was enjoyed.

Leaving Florence on the evening of October 16, we spent the following day in Washington and took advantage of the opportunity to make several con-

tacts there. We arrived in Chicago the morning of Thursday, October 18. The conference was not scheduled to begin until the following day, but we were satisfied that the time permitted by the early arrival could be profitably spent and we were not disappointed. After going briefly to the hotel on arrival, to be sure that room reservations were intact, we went to the AMA building at 535 N. Dearborn Street and in a short while contacted Tom Hendricks, the efficient executive secretary of the Council on Medical Service and Public Relations. Two or three committees were in session at the time, engaged in work preliminary and preparatory to the conference, and it was suggested that we sit in on the proceedings of the committee engaged in discussion of the possibility of establishing definite schedules of professional fees for various surgical operations. It is our understanding that an organization of the leading stock insurance companies of the nation had requested advice from the American Medical Association on this subject, to enable the insurance companies to work out a schedule for inclusion in their insurance contracts which would, as nearly as possible, meet the normal requirements and serve to indemnify the policyholder for the professional fees to be incurred for surgery.

The committee referred to consisted of an official from each of the specialty boards and was presided over by Dr. Sensennich. The discussion was spirited and there appeared to be a number of difficulties involved.

In the afternoon we returned to the AMA building and on this occasion had the opportunity to attend a meeting of the Council on Medical Service and Public Relations. Dr. E. J. McCormick, the chairman, presided, and practically all of the members of the committee were present. The principal item discussed was a report by Dr. S. J. Wall of Washington, D. C., a member of the Council, on the bill now pending in Congress for expansion of the EMIC program. Dr. Wall submitted a splendid report, informative, and revealing clearly the implications involved in this proposed legislation. We occupied a unique position in that we were the only non-members of the Council present, and were introduced and invited to make a few remarks. Dr. McLeod responded and in his usual forceful manner briefly expressed the purpose of our visit and our desire to assist and cooperate in any work for the advancement and interest of the medical profession. He expressed the view that there is a great need for a change in the attitude of the national organization. He pointed out that it is high time to take a positive stand, that the doctors, if determined to do, can direct the course of proposed legislation within the next few years, and that nothing will be accomplished by a continuation of the negative attitude generally maintained so far. Dr. McLeod's remarks were received by the group with interest, as evidenced by the response of several

members of the Council and by the developments in the course of the next two days.

The conference proper convened at 10 o'clock on Friday morning, October 19. It was divided into a series of roundtable discussions devoted to the following subjects: (1) Legislation (2) Extension of EMIC (3) The Public Relations Job, and (4) Placement of Medical Officers. The afternoon session was devoted to a similar series dealing with these subjects: (1) Prepaid Medical Insurance Plans (2) Rural Health Problems (3) Activating the 14 Point Program, and (4) Veterans Administration Plans. Each of the roundtable groups discussed its subject fully and a committee was appointed from each for the purpose of drawing resolutions for consideration by the full conference on Saturday morning.

We chose the discussion on Legislation for the morning session and that on Prepaid Medical Insurance Plans for the afternoon, feeling that these subjects were of the greatest importance, both to the President-elect in the preparation for the duties of the administration of his office and to the Director of Public Relations. It was highly complimentary to the South Carolina Medical Association that Dr. McLeod was appointed on the Resolutions Committee, consisting of three in each instance, in connection with both the roundtable discussions which he attended. The discussion on Legislation was headed by Dr. James R. McVay, as Moderator, and there were taken up in the following order, the Wagner-Murray-Dingle Bill, the Hill-Burton Bill, and Scientific Research Legislation, the Washington Front, and State Legislation. The consensus of opinion as developed from this discussion was that the Wagner-Murray-Dingle Bill probably will not receive favorable attention at any time in the near future; that the Hill-Burton Bill will probably pass; and that there is wide room for further development in a constructive manner, of the activities of the Washington office of the AMA headed by Dr. Joseph S. Lawrence. Dr. McLeod took part in this discussion and his enthusiastic, constructive remarks were very favorably received. Suggestions made by him at that time were subsequently embodied in the report of the Resolutions Committee.

The discussion in the afternoon on Prepaid Medical Insurance Plans was conducted by Dr. A. W. Adson of the Mayo Clinic, who almost immediately after the opening of the session, announced his choice of the committee on Resolutions, in order that these men might devote special attention to the discussion in preparation for their work. The committee was composed of Dr. Callahan of Kansas, Dr. McLeod of South Carolina and Dr. Holland of Connecticut. The following separate subjects were taken up: medical service plans, indemnity plans, industrial plans, and coordination with Blue Cross. Each was ably handled by a speaker chosen in advance, all of whom proved to be well qualified. The point emphasized throughout the discussion was the necessity of a national

organization of plans for prepayment of medical care and the coordination of the same with the activities of Blue Cross plans. Mr. Don C. Hawkins, an executive of the St. Paul Fire and Marine Insurance Company, discussed at some length the possibility of the purchase by the AMA or by its members as individuals, of a stock insurance company already in existence, with a view to converting the same as early as possible into a non-profit organization for the writing of prepayment medical care insurance on an indemnity basis. Prevailing sentiment appeared to be, however, in favor of the service plan idea.

Dr. McLeod participated in the deliberations of both the Resolutions Committees of which he was a member, but due to the conflict, your Director acted in his place during a portion of the time, on the Committee on Medical Insurance Plans. The resolutions reported by each of these committees appear elsewhere in this issue. The report of the committee on Legislation was referred by the General Assembly on Saturday morning back to the Council on Medical Service and Public Relations, but eventually emerged in much the same form as it had been presented by the committee. The resolutions proposed by the committee on Medical Insurance Plans were adopted without amendment, and resulted in the calling of a conference in Chicago on November 30 and December 1, for the purpose of considering and making recommendations to the House of Delegates of the AMA for national action along this line.

A delightful break in the proceedings of Friday was the luncheon at the Kungsholm, a restaurant with unusual atmosphere, at which we were the guests of the AMA.

The Saturday session was devoted entirely to receiving the reports of the committees, discussion and the adoption of resolutions. We were disappointed in the main event scheduled for that period, however. Mr. Watson B. Miller, newly appointed Federal Security Administrator, whose appointment was recommended and endorsed by the AMA and by various component state societies, was expected to address the meeting, but for some reason which was not quite clear, was unable to arrive. After remaining in session until 1 o'clock, the meeting adjourned without having heard Mr. Miller.

REFLECTIONS

The recent Public Relations Conference was one of the most encouraging developments which has taken place in organized medicine since our brief connection therewith. The whole atmosphere in Chicago was one of dissatisfaction with the inertia of the past. There was evident an attitude of straining at the bonds of pessimistic inaction, and a desire to be about some positive, constructive program for the future. We believe that everyone who attended the conference must have been sensible to the desire for

change and for active militant effort, which was plainly in the minds of the majority of those who spoke.

There may have been such meetings in the past. We doubt that there has been any meeting at which the desire for progress was so evident or where the forces behind the progressive ideal were given such free rein. The results in some small measure are already evident and should begin to take much clearer form by the time of the conference on Prepaid Medical Insurance and of the meeting of the House of Delegates early in December.

More of such conferences are sorely needed by the profession. They should be a part of the regular program of the national organization. Full discussion should be encouraged and insisted upon. And the discussion should not be confined to the members of the medical profession. Executive secretaries, Directors of Public Relations and other lay associates and friends of the profession can render some of their most valuable service through presentation of the viewpoint of those who are not doctors. They can thus help to develop a well-rounded, constructive policy, arising from a viewpoint which takes into consideration the needs and best interests of the whole population. Such an attitude, such a policy, is in the highest interest of the profession.

CONFERENCE ON MEDICAL INSURANCE

In accordance with the resolutions adopted by the Public Relations Conference in Chicago on October 20, Dr. A. W. Adson, acting in conjunction with the executive committee on the Council of Medical Service and Public Relations, has called and arranged for a meeting in Chicago, on November 30 and December 1, for the purpose of considering the problem of the necessity for a national organization for prepaid medical care insurance on a non-profit basis, and the necessity to coordinate the work of such an organization with that of the Blue Cross Plans.

Each state Medical Association has been requested to send two delegates to the conference, and agenda are being prepared. The purpose of the meeting is to consider the problems referred to above, discuss fully the possibilities of various forms which the proposed organization might take, and to draft a plan or plans to carry out the proposed objectives, to be presented with recommendations from this conference to the House of Delegates of the AMA at its meeting in Chicago immediately following, on December 3-6. The conference will be attended by Dr. Julian P. Price, Secretary, and M. L. Meadors, Director of Public Relations and Counsel, as delegates from South Carolina. The possibilities of this conference can hardly be over-estimated. The demand for a broad government controlled program for complete medical care can be met successfully and permanently only through a national plan whereby medical and surgical care, as well as hospital treatment, is made available

through a form of voluntary prepaid medical care insurance, the cost of which is sufficiently reasonable to enable those with low incomes to participate. The action of the Resolutions Committee which made the proposal, the Public Relations Conference in October, which adopted the resolution, Dr. A. W. Adson of Rochester, Minn., and those at AMA headquarters cooperating with him, in making this meeting possible, are contributions of the highest value toward the solution of this vital problem. They might well prove to be the beginnings of the movement which will preserve the status of medical practice and contribute to the preservation of the democratic way of life in the United States.

SOUTH CAROLINIANS ON AGENDA COMMITTEE

The agenda for the conference on Medical Care Insurance in Chicago on November 30 and December 1 are being prepared by a committee appointed by Dr. A. W. Adson and consisting of the following:

Dr. Jas. McLeod, Florence, S. C.
Dr. W. P. Callahan, Wichita, Kan.
Dr. H. M. Camp, Monmouth, Ill.
Dr. J. H. Howard, Bridgeport, Conn.
Mr. M. L. Meadors, Florence, S. C.

As this is written the committee is engaged in correspondence directed toward the selection of the subjects for discussion and the speakers by whom they shall be presented.

RESOLUTIONS ON MEDICAL INSURANCE PLANS

The following resolutions were adopted by the Public Relations Conference in Chicago on October 20:

"Whereas, Medical Service Plans for prepayment of medical care have been in operation in the United States since 1917 and today, with approximately twenty-one states having plans in operation or about to be placed in operation, only about eight million out of a total population of one hundred thirty-six million American people are subscribers to these plans, or only about six per cent of the total population; and

"Whereas, We hope to eliminate forever the dangers of federal control of medical practice, efforts must be made to have a larger portion of the working classes of this country insured under prepayment care plans and this seems at the present time to be possible only through a nationwide plan operative in all the states, Now, therefore, be it

"RESOLVED: That this Committee recognizes the great importance of definite action by the profession at this time with respect to prepayment for medical service; this being true, it is the recommendation of this Committee that each of the forty-eight states be given an opportunity to enter in the discussion of this vital problem. Therefore it is recommended that a meeting be called for November 30 and December 1, 1945 in Chicago, with two representatives from the medical society of each state to go thoroughly into this matter; the findings of this group to be incorporated in a resolution to be presented to the House of Delegates of the American Medical Association with a request for its approval at its meeting on December 3 to 6, 1945, and that this Committee recommends:

"First, that Dr. A. W. Adson of Rochester, Minnesota, act as chairman and call the proposed meeting on November 30 and December 1.

"Second, that the delegates to the proposed meeting consider the formation of a nucleus for the development of a program for medical service on a national basis, in correlation with the various states which now have plans in operation, and to assist those states which do not at present have medical service plans.

"Third, that a Committee be appointed at this session to prepare an agenda for the proposed meeting on November 30 and December 1, 1945."

PUBLIC HEALTH NEWS

STATE BOARD OF HEALTH REFUSES ARMY'S OFFER OF AIR BASE HOSPITAL FOR RAPID TREATMENT CENTER PLANS BEING MADE FOR NEW \$600,000 HOSPITAL

The State Board of Health has abandoned the idea of using the 250-bed Columbia Army Air Base Hospital as a rapid treatment center and will continue with its plan for a \$25,000 expansion program for the present rapid treatment center located on the Charleston Highway twelve miles from Columbia.

The CAAB Hospital was offered to the State Board of Health by the War Department for the treatment of Venereal disease patients and a special meeting of the Executive Committee was held November 7 to consider the proposal. The Committee decided to refuse the offer because operating costs would be too heavy, tenure uncertain, and the utilities service for the entire base would have to be maintained to supply the hospital.

In addition to the \$25,000 expansion program for the Public Health Hospital on the Charleston Highway, the Executive Committee also set its stamp of approval on plans being mapped out for the construction of a new \$600,000 V. D. hospital to be located within the city limits of Columbia.

Advance planning funds in the amount of \$18,000 already have been approved by the Federal Works Agency for the building of the new hospital and it is expected that the overall figure may be approved at an early date.

TUBERCULIN TESTING-METHODS AND MATERIALS

(From a Report of the Subcommittee on Case-finding procedures In Tuberculosis of the American Public Health Association)

The methods commonly used in tuberculin testing are the cutaneous (von Pirquet), intracutaneous (Mantoux), and percutaneous (Moro and patch). It is generally agreed that of these the intracutaneous test is the most accurate. It is the only one of the three that is quantitative in that a known amount of the tuberculin-stimulating substance is introduced within the tissues of the body. For this reason, it is the recommended test. The other tests have been put forward on the ground of convenience of application and freedom from the pain incident to the injection. It is believed that the disadvantages of the intracutaneous test, viz., fear and pain on the part of the patients, have been overestimated, and that these disadvantages do not furnish sufficient reason for the use of a less accurate test.

The materials used for the intracutaneous test at the present time are Old Tuberculin and the Purified Protein Derivative of Tuberculin (PPD), which is derived from Old Tuberculin and has been put forward as its active principle. It is recognized that the various preparations of Old Tuberculin on the market vary in potency, and it is universally agreed that a standard preparation of stability and uniform potency is highly desirable. Purified Protein Derivative, it is hoped, will ultimately fulfill this need.

In the meantime, it should be noted that the great

majority of all patients with clinically significant tuberculosis react not only to all the well-known types of tuberculin, including both Purified Protein Derivative and the various well-known brands of Old Tuberculin, but to small doses of any of them.

Finally, consideration must be given to the dosage employed. There is a constantly reiterated desire for a single-dose method of administering tuberculin, but since this procedure may cause severe reactions the two-dose method is more desirable. The standard doses are 0.01 mg. (first dose) and 1.0 mg. (second dose) of Old Tuberculin, and 0.00002 mg. (first dose and 0.0005 mg. (second dose) of Purified Protein Derivative Tuberculin. When the smaller dose is employed first there is relatively little danger of severe reaction, and excessively sensitive reactors are discovered without the use of a strong dose. In communities where very few cases of tuberculosis exist, it may seem more practical to use an intermediate dose. Doses of 0.1 mg. Old Tuberculin or 0.0005 mg. Purified Protein Derivative will probably elicit reaction in the great majority of the significant cases of tuberculosis, but when these dosages are employed it should be with full recognition of the possibility of strong reaction in the hyper-sensitive group who would have reacted to the 0.01 mg. Old Tuberculin or 0.00002 mg. Purified Protein Derivative.

4 COUNTIES EXPERIMENTING WITH DDT RAT DUSTING TO CONTROL TYPHUS COASTAL MEDICAL SOCIETY

The State Board of Health in cooperation with the USPHS recently began an experimental DDT rat-dusting program for the control of typhus fever in Charleston, Orangeburg, Beaufort and Marion Counties.

The four counties were selected on the basis of the greatest number of reported cases of the disease (highest rate per 100,000 population).

Under the program, rat runs and burrows in each business establishment in the 40-odd towns in the four counties will be infiltrated with a 10 per cent DDT powder every three months.

Before the first dusting is applied, each town will be sampled to determine the rat index. The rat sample will be combed to determine the flea-index per rat, and a specimen of the rat's blood will be examined for typhus infection by the Division of Laboratories.

When the dusting has been completed, each town will be sampled again and the rats combed to determine the flea-index at that time.

Dr. G. E. McDaniel, Director of the Division of Preventable Diseases, says the program is only an experiment in the control of typhus fever by exterminating rat fleas with DDT.

COASTAL MEDICAL SOCIETY

The Coastal Medical Society held its regular monthly meeting on November 15th, in Walterboro.

Dr. James H. Gressett of Orangeburg was the first speaker on the program, his subject, "Eye Conditions of General Interest." Dr. A. E. Baker of Charleston was the next speaker and his subject was "Intestinal Diverticula." This was illustrated with X-ray films of the condition.

Officers for 1946 were elected as follows: Dr. J. W. Carroll of Russellville, President; Dr. J. W. Chapman of Walterboro, Vice President; Dr. A. R. Johnston of St. George, Secretary-Treasurer.

The following resolution was adopted by a standing vote;

Whereas it has pleased our Father in His infinite wisdom to call to His Heavenly Home our beloved friend and brother physician, L. M. Stokes, of Walterboro, S. C.

Be it Resolved, That we, the members of The Coastal Medical Association express our sincere grief at his passing.

That, while we are deeply grieved, we rejoice that his character and life was such as to give inspiration to all those who came in contact with him.

That his Christian influence and unselfish devotion to his profession, his friends and his family, inspire us to live fuller and richer lives. He will be greatly missed from our meetings.

That we extend to the bereaved family our deepest sympathy and pray Gods blessing to comfort them in their great sorrow.

That a page in the minutes of our Association be dedicated to his memory and a copy of these resolutions be sent to the Family, and published in the Journal of the South Carolina Medical Association.

EIGHTH DISTRICT MEDICAL SOCIETY

The Eighth District Medical Society met in Denmark on October 30.

The main speaker of the evening was Dr. R. C. Major of Augusta, who gave an interesting and enlightening talk on "Chest Surgery." Others who gave brief talks were Dr. W. T. Brockman of Greenville, President of the State Association, Dr. J. P. Price of Florence, and Mr. M. L. Meadors of Florence. Other guests who were recognized were Dr. J. D. Guess of Greenville and Drs. N. B. Heyward, George Bunch and D. F. Adcock of Columbia.

A barbeque supper was served.

BOOK REVIEWS

"CLINICAL TRAUMATIC SURGERY"

By John J. Moorehead

W. B. Saunders Company, Philadelphia, Pa. 1945

This is a very readable book, well organized and illustrated. The author's experience has been extensive in this field as Medical Director of the New York City Transit System.

There are sections on injuries to the hands, head, chest, abdomen, and back. The section on fractures is comprehensive. The treatment advised is on the conservative side but is good.

The chapters on Traumatic Neuroses, Medical Phases of Trauma, Compensation Problems and Malfracture Units are excellent.

The author is outspoken and frank in giving his opinions throughout the book.

The book is highly recommended to any one doing traumatic or compensation work.

G. R. D.

NEWS ITEMS

Lieutenant Colonel Lawrence P. Thackston has received his discharge from the Army and has resumed his practice in Orangeburg. He limits his practice to urologic surgery.

Dr. Lane E. Mays, who served as a Flight Surgeon for the past two years, is now associated in practice with Dr. R. F. Zeigler, Jr. in Seneca. Dr. Mays is the son of Dr. W. C. Mays of Fairplay.

Dr. John F. Rainey has returned to Anderson from the Army and has reopened offices for the practice of internal medicine.

Dr. Robert Stith, who was recently discharged from the service, and who has returned to Florence, was awarded the Bronze Star Medal.

The citation reads "For meritorious services in support of combat operations from November 9, 1942, to May 2, 1945, in North Africa and Italy. As assistant chief of the medical service in an evacuation hospital Captain Stith rendered outstanding service of the skilled care and treatment of thousands of patients working under severe conditions of weather and enemy action. By his diligent performance he provided a constant inspiration and example to the of-

ficers, nurses and men working under him. In charge of pre-operative ward on the Anzio beachhead, Captain Stith calmly and skillfully performed his duties during periods of enemy shell fire and by his conduct influenced others to do the same. Through his professional attainments, persevering efforts and devotion to duty, Captain Stith contributed immeasurably to the success of his unit's medical mission."

Dr. Prentiss M. Kinney has resumed his practice in Bennettsville following forty months in the service. Dr. Kinney saw extensive service in Europe and was awarded the European theater ribbon with four battle stars and the occupational ribbon the Bronze Arrowhead for initial, assault landing, Presidential unit citation for activity on D-Day, Croix de Guerre for participation in the liberation of France, and the company meritorious service plaque.

He served as commanding officer of a medical collecting company, attached to the First, Seventh and Third armies.

Colleagues and friends of Dr. William S. Judy were saddened by the death of Mrs. Judy on September 21. Mrs. Judy had been in declining health for a number of months.

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CORRESPONDENCE

France,
9 November 1945

Secretary,
South Carolina Medical Association.

Dear Sir:

There are existing at this time in the European Theatre of Operations, conditions which are the seedlings for planned changes in the future practice of medicine. They have been present all during the actual war and were the stimulus for many thousands of rightful "gripes" by the doctors in the service. Now that the war is over these injustices are still present, and it is high time that they be aired, so as to preserve our present standards of medical practice and thus continue to insure the American people the highest degree of health.

We are writing this letter to you to acquaint you with these conditions which are planned adjuncts to the collaring and slow choking of the American medical profession.

1. Much has already been said and written concerning the surplus of doctors in service, and the hoarding of this surplus by the Military. This unnecessary disproportion was present, but tolerated, during the actual time of combat. At that time there was one doctor per two hundred soldiers. From the available casualty figures published by the Army and Navy, during the entire European and Pacific war, there was available one doctor for every ten soldiers injured. Compare this figure with the civilian figure where one doctor serves one thousand people of all ages and of both sexes. Now with the war over, combat casualties non-existing, and redeployment of the troops "excluding medical officers," this disproportion grows even more alarming and ridiculous. We find ourselves with no work to do sitting idly here, simply political prisoners. Is this not a sufficient contradiction to the plea of "necessity" to arouse in us a suspicion and fear of a sinister plot of the greedy social planners? Do we read socialized medicine in the offing? We are sure we do. We don't like it. We don't want it.

2. A second inciting factor of the present medical situation is the policy of the Army to refrain from inducting into the service those young men who were given a medical and dental education at the expense of the Government. These young men are not being sent overseas as replacements, while doctors with 15 to 24 months overseas service or two to three years total service are being kept here, many to serve in the Army of Occupation. This contradiction to logic, this breach of everything that is right, just, and holy is leaving a mark of bitterness in us doctors that even time will not erase. We ask, "Is the Army keeping the older men, those with long overseas service, away from the States to curry favor with the younger man in the hope and play of entwining him in their scheme of socialization.

3. Along the same line, doctors at home, who have never left the States are being discharged with fewer points than many doctors have who are overseas. They are being discharged, and we can't even get home. Again we ask ourselves a question, "Is this justice, or are we making a mistake by expecting justice?"

The result of these injustices is becoming very evident to us who are witnessing these experiences. The

doctor has no work, he is loafing, he is losing his initiative, his desire for and interest in medicine. He is developing a mental attitude which if it continues to be nourished by instances as above, will solidify into a bloc, not only willing to accept, but encouraging socialized medicine. This is not an idle dream, this is now on everyday conversation and admission, spoken no longer with hesitancy, nor with shame, and with less and less regrets. The future is not rosy. Is it the desire of the representative leaders of our profession to see as a result of this neglect, an embittered bloc of medical people arise? A bloc so frustrated that the advent of socialized medicine would be a welcome refuge. We think not, and we hope not. Unless something is done immediately, these grave fears will come to pass.

In an effort to avoid this we offer the following suggestions:

1. Let there be adequate medical personnel for American soldiers in each theatre. No more, no less.

2. Get the surplus of those overseas home immediately. There is an overwhelming surplus. Get those with long overseas service home now. They can't take much more now.

3. Let the A. S. T. P. and V-12 doctors earn their Government education by a tour of duty overseas thereby allowing the poor, forgotten, disillusioned, lethargic doctor a chance to return home because he is now filled with ennui such that he doesn't know if he is coming or going!

4. The American Medical Association should pursue its function of protecting the rights of its members. Let us not again see the Journal repeat, without criticism, the exorbitant demands of the Army. It nauseates us who know the true state of affairs, and is an insult to our intelligence.

5. We think too that after the cessation of hostilities there ought to be at least a degree of medical autonomy. A representative committee of the profession should have the power to decide how many doctors for the Military and how many for the civilian population.

The future of individualistic American medicine is in the balance. You can tip the scales in the right direction. But it must be done now.

A Representative Group of
Medical Officers.

Distribution —

1. Deans of approved medical colleges.
2. Secretaries of State Medical Societies.
3. Representative individual leaders of the medical profession.
4. Secretaries of the American College of Physicians, and the American College of Surgeons.
5. Leading newspapers and periodicals.

DEATHS

Dr. Robert H. Ariail, 40, died at his home in Laurens on November 12 after a brief illness.

A graduate of the Medical College of the State of S. C. (1929), Dr. Ariail located at Laurens in 1930 where he carried on a large practice up until the time of his death. He is survived by his widow (the former Miss Minnie Philson Ray of Laurens) and three children, by seven brothers and sisters, one of whom is Dr. Clyde Ariail of Greenville.



FOURTH IN A SERIES OF CHALLENGES TO MEDICINE'S

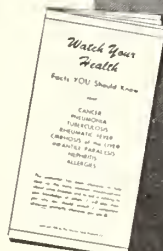
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POLIOMYELITIS is a dreaded disease. The virus has been isolated and many of its habits are known. But — we must find out why it strikes down some, yet fails to make others sick, and we must discover some method of immunizing susceptible persons against the insidious polio virus.

Until research leads us to the solution, the public should continue to be educated — given the facts about polio so they will not become panicky during an epidemic, but will know how to employ the best preventive measures.

In the pamphlet "Watch Your Health" we have given such information on poliomyelitis—one of the seven serious diseases discussed. Copies for distribution to your patients are available on request.



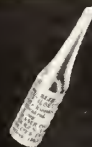
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Pathological Conference, Medical College of the State of South Carolina

KENNETH M. LYNCH, M.D., PROFESSOR OF PATHOLOGY

ABSTRACT NO. 561

Student R. J. Davis, presenting:

History: 27 year old white woman who was in good health until 3 weeks before admission. At that time she began to menstruate; associated with this was a sharp pain in her left side. This pain subsided to a dull ache and later increased progressively in intensity. Ten days prior to admission, she first noted a swelling in the LLQ. The day before admission, she began to menstruate and have sharp LLQ pains. She said that at this time she believed the mass in her left side increased slightly in size which it had not done previously.

For about 1 year, she had had some vague lower back pain, not associated with her menstrual period. Menstrual History: 13 x 21 x 6, moderate dysmenorrhea but no previous sharp pains. No pregnancies, missed periods nor leukorrhea. Anti-leucic treatment for one year.

No nausea, vomiting nor diarrhea, but for past month she had had some "slight constipation."

Physical: T 99.8 P 90 R 22 B. P. 120/62. Well developed and nourished white patient in much pain but not acutely ill. Neck, chest, and lungs negative.

Abdomen: In the LLQ, was a large, fixed, hot, very tender mass. Deep fluctuation was thought to be present. Percussion over the left flank posteriorly as well as over the lumbar spinous processes produced extreme pain.

Pelvic Exam.: Uterus small, not retroverted; movable without fixation. No mass in pelvis. Tender mass fixed above pelvic brim on left.

Laboratory: Urinalysis (Cath.) Neg. except for 1-2 WBC.

Blood (On adm.) WBC 10,350 with 89% polys 10% lymphs and 1% mono; Hb 10.5 gms. (9 days later) 21,500 WBC with 91% polys. Wass. and Kline positive. Mantoux Neg.

Roentgenographic Exam.: The right kidney is normal in size, shape and position. The left kidney is normal in position, but moderately enlarged. No evidence of urinary calculi.

Course: Daily rise of temperature to 101.5° or 103.5°. Ten days after admission an operation was performed.

Dr. H. G. Smithy (conducting): Mr. Snyder, what is your interpretation of this case.

Student Synder: The history suggests some gynecological problem, but the physical findings are inconsistent. Nevertheless, I considered torsion of an ovarian cyst situated high in the pelvis, although it seems unlikely that it would have produced the type of mass that is described here. Rupture of an ectopic pregnancy must be mentioned, but the history as well as the physical findings fail to help us. Diverticulitis of sigmoid colon with slow perforation and abscess formation would satisfy most of the findings. A perinephritic abscess must also be eliminated. The tenderness over the left flank and spinous processes adds strength to this diagnosis. Urinary findings are often lacking and the purulent exudate could dissect its way into the left lower quadrant. The initial symptoms seem scarcely acute enough for a perinephritic abscess, however, a psoas abscess could also point in this vicinity, but is unlikely. The negative Mantoux is also against it. Granulomatous disease, such as

actinomycosis, of the sigmoid colon enters the picture, but it is much more apt to involve the cecal area and does not generally produce a hot tender mass. Of all these conditions, I think diverticulitis with localized abscess to be the most likely.

Dr. Smithy: Mr. Griffin, what other granulomatous diseases may be considered here?

Student Griffin: She has a positive Wasserman, so syphilis must be considered. Lymphopathia venereum is even more worthy of consideration, as it often produces stricture of the lower intestine. Personally, I think diverticulitis with rupture is the best diagnosis.

Dr. Smithy: Why didn't the patient have generalized peritonitis?

Student Griffin: The peritonitis resulting from a perforated diverticulum is usually localized, as the rupture is apt to be slow and the mesocolonic fat helps to wall it off. I think that a psoas abscess must still be borne in mind, although it usually presents in the femoral triangle or loin.

Dr. Smithy: Mr. North, what other granulomatous disease must be considered?

Student North: Tuberculosis, syphilis, fungus disease or lymphopathia are the only ones of which I am aware.

Dr. Smithy: Regional ileitis or enteritis may involve the colon and cause perforation and abscess. It is often a chronic smoldering affair. Did you consider any other possibilities?

Student North: I did consider endometriosis of the colon with hemorrhage and infection. This would explain the seeming relationship to the menses. I think X-ray studies of the colon might be helpful.

Dr. Smithy: Mr. Davis will show the films and you can interpret them.

Student North: There is an annular constricting lesion of the sigmoid colon.

Dr. Smithy: Yes. The radiologist's report is as follows: "Radiographic and fluoroscopic study of the colon with barium enema shows the following: At the junction of the sigmoid with the descending portion of the colon, there is a definite 'napkin' ring filling defect which is constant on all radiographs. The borders of this are quite irregular and it extends for a distance of about 1½ inches. The remainder of the colon filled out normally.

The appearance of this lesion is very suggestive for carcinoma. It could be produced by an extreme inflammatory lesion of the wall at this point, but we believe that carcinoma must be ruled out. Well, what do you think now.

Student North: Well, I still think there was an abscess in this region and see no reason why a carcinoma cannot perforate just as a diverticulum, but certainly the course, abscess of obstruction and age are quite atypical.

Dr. Pratt-Thomas: *Final Pathological Diagnosis: Mucoid Carcinoma of Colon with Peritoneal Implantation and Infiltration of Abdominal Wall. Pneumonia, Acute, Lobular. Pyelonephritis, Acute, Suppurative.*

When a necropsy was performed on this patient 10 months after the operation, the disease was much more extensive than it had been at operation. At operation an inoperable gelatinous carcinoma of the

How irritation varies from *different* cigarettes

Tests made on rabbits' eyes reveal the influence of hygroscopic agents*

TYPE OF CIGARETTE	
1 Edema 0.8	Cigarettes made by the PHILIP MORRIS method
2 Edema 2.1	Cigarettes made with no hygroscopic agent
3 Edema 2.7	Popular cigarette #1 (ordinary method)
4 Edema 2.6	Popular cigarette #2 (ordinary method)
5 Edema 2.7	Popular cigarette #3 (ordinary method)
6 Edema 2.7	Popular cigarette #4 (ordinary method)

CONCLUSION:* Results show that regardless of blend of tobacco, flavoring materials, or method of manufacture, the irritation produced by all ordinary cigarettes is substantially the same, and measurably greater than that caused by PHILIP MORRIS.

CLINICAL CONFIRMATION:** When *smokers* changed to PHILIP MORRIS, substantially every case of irritation of the nose and throat due to smoking cleared completely or definitely improved.

*N. Y. State Journ. Med. 35 No. 11,590 **Laryngoscope 1935, XLV, No. 2, 149-154

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

descending sigmoid had been found. At necropsy fecal fistulae were present and the carcinoma had penetrated the abdominal wall in both lower quadrants and extended down beneath Pourpart's ligament on the left. It had also invaded the posterior parietal peritoneum, thus causing partial ureteral obstruction and resultant hydronephrosis. Histologically the neoplasm was of very low grade with quantities of extracellular mucus. The patient terminally had a suppurative pyelonephritis and acute lobular pneumonia.

One is apt to think of neoplastic disease as a

condition affecting older people, and although generally true, there are many exceptions. Within the past four years we have seen at least 10 malignancies of the digestive system in people less than 30 years of age. One of these was a negro youth, age 18, with carcinoma of the rectum. Three were carcinomas of the stomach in patients 24, 22, and 21 years of age, respectively. Another was carcinoma of the pancreas in a negro age 23. Thus we see that neoplastic disease must always be considered in the differential diagnosis, even though the patient does not fall into the generally accepted cancer age group.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. Vance W. Brabham, Orangeburg, S. C. Publicity Secretary: Mrs. P. J. Boatwright, Orangeburg, S. C.

The Executive Board of the Woman's Auxiliary to the South Carolina Medical Association met on October 2nd, 1945 in the Legion Room of the Wade Hampton Hotel in Columbia for its regular Fall meeting. Mrs. Vance W. Brabham, of Orangeburg presided at the meeting. Rev. Leo D. Gillespie of Columbia opened the meeting with a very fitting devotional. The business session followed immediately. In the absence of the recording secretary, Mrs. J. C. Josey of Spartanburg, the minutes were read and recorded by Mrs. David F. Adcock of Columbia. The President's mid-year report was given most completely and inspiringly by Mrs. Brabham and includes what had been accomplished during the first half of the year, and four very definite aims for the last half of the year. These aims are as follows: First—To help educate the public on Animal Experimentation. Second—To help eradicate the Black Market in Babies. Third—To increase Nutrition Education and Fourth—To stimulate public interest in Accident Prevention and Community Safety. The report closed with a striking poem which exactly fitted its place.

A nominating committee was elected as follows: Mrs. W. H. Folk, Spartanburg, Chairman; Mrs. A. F. Burnside, Columbia and Mrs. W. O. Whetsell, Orangeburg. Following the adjournment, the Board was entertained at a luncheon by the president, Mrs. Brabham. The Palmetto Room of the Wade Hampton Hotel was used. The table decorations featured fall flowers in an autumn color scheme shading from yellow to deepest orange. Dr. H. L. Timmons of Columbia, Chairman of the Advisory Council of the Woman's Auxiliary to the South Carolina Medical Association

was the luncheon speaker. He spoke most impressively of the part a doctor's wife plays in her husband's life and work.

Various committee reports followed as well as reports by the County Presidents. Dr. Thomas Brockman, President of the South Carolina Medical Association was present and spoke on the subject "Does South Carolina Need a Basic Science Law?" Dr. Kenneth M. Lynch, Dean of the Medical College of South Carolina was also present and spoke on the Expansion Program for the Medical College.

Mid-Year Report and Plans of the President

Your President begs to submit the following report from April 17th to October 3rd, 1945.

The months following our meeting in April have been busy months with considerable correspondence to both National and State Officers.

Stationery carrying the names of State Officers was printed and mailed to all members of the Executive Board.

Greetings were sent to Mrs. David Thomas, of Lock Haven, Pennsylvania, President of the Woman's Auxiliary to the American Medical Association.

Your President has spoken at one County Auxiliary meeting and has accepted an invitation to meet with another one soon.

For the third successive year, your President is serving as Co-chairman of Organization for the Southeastern States with Mrs. Eustace Allen, First Vice President of the Woman's Auxiliary to the American Medical Association. Plans are being made to attend the meeting of the Woman's Auxiliary to the Southern Medical Association in Cincinnati on

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November 12th. Your President will also attend the Fall Executive Board meeting of the Woman's Auxiliary to the American Medical Association in Chicago in November. An earnest effort will be made to bring back to our State and County Auxiliaries both information and inspiration in carrying forward our work for the year.

Special emphasis will be directed toward helping our Organization Chairman in her efforts to organize new County Auxiliaries this year. We need new growth in order to go forward.

The Bulletin is your Auxiliary magazine. Let us have for our goal, "Every member a subscriber to the Bulletin."

Hygeia, the only authentic health magazine of national circulation, enjoys a large subscription list but deserves wider circulation. Its increased use in homes, offices, schools, industry and libraries is most desirable. Let us work toward that end.

As doctor's wives, one of the most important tasks we have today is to acquaint ourselves with pending legislation which has a tendency to affect the entire medical profession.

Juvenile Delinquency is still a very definite part of our program as is the Physical Fitness Program.

Our work in Cancer Control, Infantile Paralysis and all other phases of public health are definite ways of extending the aims of the medical profession to the public.

The American Medical Association has given the Auxiliary a number of projects for our earnest consideration in post war planning.

First: We are asked to help educate our people on the subject of Animal Experimentation in order that the marvelous growth of medical science may not be interfered with but may continue to benefit mankind without hampering legislation, or false and dishonest propaganda.

Second: We are asked to take an active interest in the eradication of the Black Market in Babies. This black market has grown to such an alarming extent that State Legislatures, who now have hit and miss adoption methods, have asked the Department of Labor for advice on revision of their adoption laws,

in order to better protect the welfare of children up for adoption and to safeguard the foster parents.

Third: We are asked to do our part toward building up the health of our Nation by an educational program designed to stress the importance of well balanced and well prepared meals. We must help educate the people to the fact that Vitamin tablets, while they serve a purpose, are not a substitute for a well prepared meal, that the worker and the school child need a good breakfast, and that fads in diet are dangerous.

Fourth: We are asked to take the leadership in our communities in stimulating public interest in accident prevention and to promote community safety. The prevention of accidents in the home, and automobile accidents should be especially stressed.

Holding a membership in the medical auxiliary is a great privilege which in turn carries with it many responsibilities to both the medical profession and to our respective communities.

The post war period will bring many new problems, which cannot be foreseen at this time. We must be ever watchful and alert so that we shall be adequately prepared and able to meet whatever demands are made upon us. May we always hold to the high ideals and true spirit of medicine, and thereby be inspired to do the quality of work which will prove us to be worthy of being a part of such a noble profession.

"We all have a share in the beauty,
We all have a part in the plan,
What does it matter what duty
Falls to the lot of man.

"Some one must blend the plaster,
Some one must carry the stone,
Neither the man nor the master
Ever has builded alone.

"Making a roof from the weather
Or building a house for a King
Only by working together have
Men ever accomplished a thing."

NEWS ITEM

The American College of Physicians will resume its Annual Meetings in 1946 and has now definitely chosen Philadelphia, May 13-17, inclusive. Headquarters will be at the Philadelphia Municipal Auditorium, 34th Street below Spruce.

The Meeting will be conducted under the Presidency of Dr. Ernest E. Irons, Chicago, Illinois, and the General Chairmanship of Dr. George Morris Piersol, Philadelphia, Pennsylvania.

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Bates, W. L.-----	Greenville, S. C.	Brewer, J. M. (S)-----	Kershaw, S. C.
°-----	Designates Honorary Member	Brice, J. M.-----	Kingstree, S. C.
(S)-----	Designates Member in Service	Bristow, W. J.-----	Columbia, S. C.

Brockman, W. T.-----Greenville, S. C.
 Brodie, J. E. (S)-----Greenwood, S. C.
 Brooker, L. C.-----Swansea, S. C.
 Brooks, T. G. (S)-----Aiken, S. C.
 Brown, A. E.-----Greenville, S. C.
 Brown, G. C., Jr. (S)-----Walterboro, S. C.
 Brown, R. Kyle-----Greenville, S. C.
 Browning, A. W.-----Florence, S. C.
 Bruce, John L.-----Florence, S. C.
 Brunson, Francis (S)-----Sumter, S. C.
 Brunson, J. E.-----Taylors, S. C.
 Brunson, J. W. (S)-----Camden, S. C.
 Brunson, P. A.-----Ridge Springs, S. C.
 Brunson, Sophia°-----Sumter, S. C.
 Bryan, L. S. (S)-----Columbia, S. C.
 Bryson, E. J.-----Liberty, S. C.
 Buckner, Margaret-----McColl, S. C.
 Buist, A. J., Jr.-----Charleston, S. C.
 Bullock, C. T.-----Mullins, S. C.
 Bultman, R. B. (S)-----Sumter, S. C.
 Bunch, G. H.°-----Columbia, S. C.
 Bundy, J. L.-----Rock Hill, S. C.
 Burgess, W. H.°-----Sumter, S. C.
 Burgess, W. S.-----Sumter, S. C.
 Burn, J. Walter°-----Charleston, S. C.
 Burnside, A. F.-----Columbia, S. C.
 Byerly, W. L.-----Hartsville, S. C.

Cain, Frank G.-----Charleston, S. C.
 Cain, J. P., Jr.-----Mullins, S. C.
 Callison, H. G.-----Columbia, S. C.
 Camp, Ned-----Anderson, S. C.
 Campbell, S. D.-----Piedmont, S. C.
 Campbell, T. A.-----Blacksburg, S. C.
 Cannon, E. Gaine-----Pickens, S. C.
 Cannon, J. H.-----Charleston, S. C.
 Cannon, William M.-----Charleston, S. C.
 Carnes, W. C. (S)-----Lancaster, S. C.
 Carpenter, F. L.-----Latta, S. C.
 Carpenter, W. M.-----Greenville, S. C.
 Carrigan, G. B.-----Columbia, S. C.
 Carrigan, W. A.°-----Society Hill, S. C.
 Carroll, J. W.-----Russellville, S. C.
 Carroll, T. B.-----Hardeeville, S. C.
 Carter, J. T.-----Spartanburg, S. C.
 Carter, Patricia A.-----Charleston, S. C.
 Cash, J. B.-----Chesnee, S. C.
 Cashwell, R. L.-----Greenville, S. C.
 Cathcart, Hugh (S)-----Charleston, S. C.
 Cathcart, J. H.-----Gaffney, S. C.
 Cathcart, R. S.°-----Charleston, S. C.
 Chamberlain, O. B. (S)-----Charleston, S. C.
 Chambers, G. W.-----Anderson, S. C.
 Chance, F. S. (S)-----Chester, S. C.
 Chandler, J. J.-----Sumter, S. C.
 Chapman, J. W.-----Walterboro, S. C.
 Chapman, William H.°-----Whitney, S. C.
 Chappell, B. S. (S)-----Columbia, S. C.
 Chappell, R. H.-----Greenville, S. C.
 Charles, Randolph C.-----Bennettsville, S. C.
 Cheatham, M. W.-----Columbia, S. C.
 Clark, N. T.-----Spartanburg, S. C.
 Claussen, John R.-----Florence, S. C.

Clayton, H.°-----Hopkins, S. C.
 Cleckley, J. J. (S)-----Bamberg, S. C.
 Clement, Mortimer T.-----Navy Yard, S. C.
 Clinkscales, C. S.-----Anderson, S. C.
 Cochran, E. D. (S)-----Spartanburg, S. C.
 Cochran, William N.-----Spartanburg, S. C.
 Cockfield, R. L.-----Lake City, S. C.
 Coffee, H. D.-----Columbia, S. C.
 Coleman, F. P. (S)-----Columbia, S. C.
 Coleman, L. H.-----Spartanburg, S. C.
 Coleman, Ralph R.-----Charleston, S. C.
 Coleman, Stanley I.-----Travelers Rest, S. C.
 Cone, G. Preston-----Orangeburg, S. C.
 Cone, Wallis-----Williston, S. C.
 Connor, P. M.-----Neeses, S. C.
 Converse, Joe P. (S)-----Greenville, S. C.
 Cook, W. C.-----Columbia, S. C.
 Corbett, J. W.°-----Camden, S. C.
 Corbett, W. M., Jr.-----Columbia, S. C.
 Corn, Charles P.-----Greenville, S. C.
 Cox, Marcus E. (S)-----Charleston, S. C.
 Crawford, R. L.-----Lancaster, S. C.
 Crawley, W. G. (S)-----Lancaster, S. C.
 Crook, Martin-----Spartanburg, S. C.
 Crooks, J. H.-----Greenville, S. C.
 Crosby, C. E.-----Greenwood, S. C.
 Crosland, Joe E.-----Greenville, S. C.
 Crosson, James-----Leesville, S. C.
 Crow, Robert-----Cowpens, S. C.
 Cudd, J. E.-----Spartanburg, S. C.
 Culbreath, Paul H.-----Ellenton, S. C.
 Culler, O. Z.-----Orangeburg, S. C.
 Cutchin, Joe H.-----Easley, S. C.
 Cuttino, J. T. (S)-----Columbia, S. C.

Dacus, R. M., Jr. (S)-----Greenville, S. C.
 Daniel, H. M.-----Anderson, S. C.
 Daniels, F. M.-----Greenville, S. C.
 Danner, J. H.-----Holly Hill, S. C.
 Darwin, J. T.°-----Gaffney, S. C.
 Davenport, J. F.-----Timmonsville, S. C.
 Davis, H. G. (S)-----Greenville, S. C.
 Davis, J. M. (S)-----Columbia, S. C.
 Davis, J. T.-----Walhalla, S. C.
 Davis, J. W.°-----Clinton, S. C.
 Davis, L. C.-----Columbia, S. C.
 Dawson, George R.-----Florence, S. C.
 Deas, Henry-----Charleston, S. C.
 Dendy, W. Steele-----Pelzer, S. C.
 De Saussure, H. W.-----Charleston, S. C.
 DesPortes, J. R.°-----Fort Mill, S. C.
 Dibble, E. M.°-----Marion, S. C.
 Dillard, J. A.-----Columbia, S. C.
 Dobson, J. F.-----Ridgeway, S. C.
 Dotterer, T. D. (S)-----Columbia, S. C.
 Doughty, R. G.-----Columbia, S. C.
 Dove, H. R.-----Columbia, S. C.
 DuBose, T. M., Jr.-----Columbia, S. C.
 Dulin, Thomas N.°-----Clover, S. C.
 Dunlap, J. O.-----Rock Hill, S. C.
 Dunn, J. R.-----Sumter, S. C.
 Dunnivant, R. B.-----Edgefield, S. C.
 Durham, I. D.-----West Columbia, S. C.

Durham, R. B.-----Columbia, S. C.
Durst, George G. (S)-----Columbia, S. C.

Eaddy, A. M. (S)-----Columbia, S. C.
Eaddy, N. O. (S)-----Sumter, S. C.
Eargle, H. M.-----Orangeburg, S. C.
Earle, J. B.°-----Greenville, S. C.
Edwards, G. B.°-----Darlington, S. C.
Edwards, Georgina-----Abbeville, S. C.
Edwards, H. A.-----Latta, S. C.
Edwards, Preston H.-----Conway, S. C.
Edwards, W. W. (S)-----Greenville, S. C.
Elliott, J. B.-----Fort Mill, S. C.
Ellis, Daniel W.-----Charleston, S. C.
Elvington, Robert F.-----Lake View, S. C.
Epps, C. B.°-----Sumter, S. C.
Epting, C. H.-----Columbia, S. C.
Epting, E. E.-----Anderson, S. C.
Eskrigge, Edith-----Columbia, S. C.
Estes, Amos C.-----Winnsboro, S. C.
Evans, Dexter M.-----Lake City, S. C.
Evans, William (S)-----Bennettsville, S. C.
Evatt, Clay W.-----Charleston, S. C.

Fair, C. H. (S)-----Greenville, S. C.
Fairey, T. K.-----Johnston, S. C.
Farmer, Rudolph-----State Park, S. C.
Fender, M. S.-----Ehrhardt, S. C.
Fennell, J. L.°-----Waterloo, S. C.
Fennell, W. W.-----Rock Hill, S. C.
Fewell, John M.-----Greenville, S. C.
Fewell, W. S.-----Greenville, S. C.
Finger, Elliott (S)-----Marion, S. C.
Finklea, O. T.-----Florence, S. C.
Finney, Claude S. (S)-----Spartanburg, S. C.
Finney, Roy P.-----Spartanburg, S. C.
Fishburne, S. B.°-----Columbia, S. C.
Fishburne, W. K.-----Moncks Corner, S. C.
Fleming, John M. (S)-----Spartanburg, S. C.
Floyd, J. B.-----Great Falls, S. C.
Floyd, L. C.-----Olanata, S. C.
Folk, W. H. (S)-----Spartanburg, S. C.
Ford, B. F. (S)-----St. Matthews, S. C.
Forte, J. A.-----North, S. C.
Fouche, J. S.-----Columbia, S. C.
Fouche, J. W. (S)-----Columbia, S. C.
Fox, W. M. (S)-----Columbia, S. C.
Frampton, James°-----Mt. Pleasant, S. C.
Frampton, W. H.-----Charleston, S. C.
Freed, J. E. (S)-----Columbia, S. C.
Fulenwider, J. O. (S)-----Pageland, S. C.
Fulmer, W. E.°-----Columbia, S. C.
Funderburke, I. S.-----Cheraw, S. C.
Furman, R. B.°-----Sumter, S. C.
Furman, Thomas C.-----Greenville, S. C.

Gaydosh, Francis J.-----Spartanburg, S. C.
Gaillard, Peter C. (S)-----Beaufort, S. C.
Gaines, T. R. (S)-----Anderson, S. C.
Gantt, R. B.-----Charleston, S. C.
Garrett, J. F.-----Greenville, S. C.
Garvin, O. D. (S)-----Spartanburg, S. C.
Gaston, F. P. (S)-----Rock Hill, S. C.

Gaston, J. N., Jr.-----Chester, S. C.
Gaston, J. N., Sr.-----Edgmoor, S. C.
Gaston, S. R.-----Travelers Rest, S. C.
Geiger, F. L.-----Columbia, S. C.
George, W. E.-----Columbia, S. C.
Gibbes, J. H.-----Columbia, S. C.
Gibbes, R. W.°-----Columbia, S. C.
Gibbs, W. R.-----Buffalo, S. C.
Gibson, W. T.-----Batesburg, S. C.
Gilmore, H. S.-----Nichols, S. C.
Glennon, T. L.-----Denmark, S. C.
Goings, J. G.°-----Union, S. C.
Goldsmith, T. G.-----Greenville, S. C.
Goodlett, O. M., Jr.-----Pelzer, S. C.
Goodwin, C. I.-----Holly Hill, S. C.
Graham, B. (S)-----Clinton, S. C.
Graham, Charles M.-----Clio, S. C.
Gray, Ellis B.-----Coconut Grove, Florida
Green, J. T. (S)-----Columbia, S. C.
Gregg, D. B.-----Charleston, S. C.
Gressette, J. H.-----Orangeburg, S. C.
Griffin, H. H.°-----Columbia, S. C.
Griggs, D. C.-----Pageland, S. C.
Grigsby, W. D.°-----Blaney, S. C.
Grimball, I. H.-----Greenville, S. C.
Gross, H. A.-----Barnwell, S. C.
Guerry, LeGrande°-----Columbia, S. C.
Guess, J. D.-----Greenville, S. C.
Guigner, J. B.°-----Columbia, S. C.
Gunn, Audrey-----Columbia, S. C.
Guyton, C. L. (S)-----Columbia, S. C.

Haddock, S. H.-----Anderson, S. C.
Hair, J. T. (S)-----Aiken, S. C.
Hall, H. F. (S)-----Columbia, S. C.
Hall, H. T.-----Aiken, S. C.
Hall, J. C.-----Gaffney, S. C.
Hall, L. F.-----Columbia, S. C.
Hall, T. G.-----Westminster, S. C.
Hall, W. S. (S)-----Columbia, S. C.
Ham, Coyt.-----Columbia, S. C.
Hamilton, R. G.-----Columbia, S. C.
Hanckel, Richard W.-----Charleston, S. C.
Hankins, T. C. (S)-----Marion, S. C.
Hardy, B. F.-----Dillon, S. C.
Hardy, J. T.-----Winnsboro, S. C.
Harper, Dewitt L.-----Greenville, S. C.
Harper, J. C.-----Greenwood, S. C.
Harper, T. B.-----St. Stephen, S. C.
Harris, H. H.-----Anderson, S. C.
Harris, J. C.-----Lancaster, S. C.
Harrison, J. D.-----Greenwood, S. C.
Harrison, J. P.-----Cheraw, S. C.
Harrison, John R.-----Greer, S. C.
Hart, John G.-----Laurens, S. C.
Hart, W. A.-----Columbia, S. C.
Harter, J. W. (S)-----Orangeburg, S. C.
Hartzog, L. A.°-----Olar, S. C.
Harvin, W. S.-----Manning, S. C.
Hay, P. D.-----Florence, S. C.
Hayne, Isaac-----Congaree, S. C.
Hayne, J. Adams°-----Columbia, S. C.
Hayne, James A., Jr.-----Hampton, S. C.
Haynie, James W.-----Honea Path, S. C.

Haynic, W. R., Sr.°-----Belton, S. C.
 Haynsworth, Curtis H.-----New York, N. Y.
 Hays, S. C.-----Clinton, S. C.
 Hearn, Paul P. (S)-----Greenville, S. C.
 Heidt, G. Frank-----Charleston, S. C.
 Heise, E. A.-----Sumter, S. C.
 Hendrix, W. T.-----Spartanburg, S. C.
 Hennies, George A.-----Chester, S. C.
 Henry, W. J.-----Chester, S. C.
 Hentz, E. O.-----Anderson, S. C.
 Herbert, H. W. (S)-----Florence, S. C.
 Herlong, E. E.-----Rock Hill, S. C.
 Herring, H. D.-----North Charleston, S. C.
 Hewitt, Ragsdale-----Sumter, S. C.
 Heyward, N. B.-----Columbia, S. C.
 Hicks, E. M.-----Florence, S. C.
 Hicks, R. D.-----Chester, S. C.
 Hicks, W. E.-----Timmons ville, S. C.
 Hiers, H. G.-----Bamberg, S. C.
 Hill, John B.-----Greenville, S. C.
 Hill, J. C.°-----Abbeville, S. C.
 Hill, Robert D.-----Pacolet, S. C.
 Hinson, A. (S)-----Rock Hill, S. C.
 Hiott, J. T.-----Charleston, S. C.
 Hogan, O. F.-----Greelyville, S. C.
 Holler, J. E.-----Columbia, S. C.
 Holley, O. C.-----Leesville, S. C.
 Holloway, W. J. (S)-----Ware Shoals, S. C.
 Holman, D. O.-----Timmons ville, S. C.
 Holmes, Gertrude (S)-----Greenville, S. C.
 Holtzclaw, J. N.-----Greenville, S. C.
 Hood, E. C.-----Darlington, S. C.
 Hood, W. A.°-----Hickory Grove, S. C.
 Hook, M. W.-----Cheraw, S. C.
 Hope, A. C.-----Union, S. C.
 Hope, H. P.-----Union, S. C.
 Hope, R. M.-----Charleston, S. C.
 Hopkins, T. J.-----Columbia, S. C.
 Horger, E. O., Jr.-----Greenville, S. C.
 Horton, C. C.-----Pendleton, S. C.
 Hoshall, F. A.-----Charleston, S. C.
 Houck, T. H.-----Florence, S. C.
 Houseal, R. W. (S)-----Newberry, S. C.
 Houston, R. E.-----Greenville, S. C.
 Howell, J. R.-----Aiken, S. C.
 Howell, J. T.-----Florence, S. C.
 Hughes, James L.-----Greer, S. C.
 Hughston, George F.-----Fairforest, S. C.
 Humphries, A. W.-----Camden, S. C.
 Hunter, J. H.°-----Spartanburg, S. C.
 Hunter, P. W.-----York, S. C.
 Hutchinson, M. E. (S)-----Columbia, S. C.
 Huth, P. E. (S)-----Sumter, S. C.
 Hutto, A. T.-----Pelion, S. C.

James, F. G.°-----Greer, S. C.
 Jeanes, R. P. (S)-----Easley, S. C.
 Jenkins, P. G.-----Charleston, S. C.
 Jennings, Douglas-----Bennettsville, S. C.
 Jervey, J. W., Jr.-----Greenville, S. C.
 Jervey, J. W., Sr.°-----Greenville, S. C.
 Jewell, J. C.-----Piedmont, S. C.
 Johnson, Allen H.-----Hemingway, S. C.

Johnson, F. B.-----Charleston, S. C.
 Johnson, George D.-----Spartanburg, S. C.
 Johnson, H. M.-----West Columbia, S. C.
 Johnson, Joseph A.-----Marion, S. C.
 Johnston, A. R., Jr.-----St. George, S. C.
 Jordon, F.°-----Greenville, S. C.
 Josey, A. I. (S)-----Columbia, S. C.
 Josey, J. C.-----Spartanburg, S. C.
 Josey, R. B. (S)-----Columbia, S. C.
 Judy, W. S.-----Greenville, S. C.

Keels, L. B. (S)-----Lynchburg, S. C.
 Keisler, D. S.-----Leesville, S. C.
 Kell, T. B.°-----Fort Lawn, S. C.
 Kelley, William H.-----Charleston, S. C.
 Kendall, B. W.-----Columbia, S. C.
 Kennedy, F. A.-----Langley, S. C.
 Kennedy, G. L.-----Ninety Six, S. C.
 Kibler, C. L.°-----Columbia, S. C.
 Kinard, D. D.-----Greenwood, S. C.
 King, E. H.-----Hartsville, S. C.
 King, Hazel B.-----Lake City, S. C.
 King, W. W.-----Batesburg, S. C.
 Kinney, C. A.-----Florence, S. C.
 Kinney, P. M. (S)-----Bennettsville, S. C.
 Kirkpatrick, L. R.-----Ware Shoals, S. C.
 Kitchin, J. W. (S)-----Liberty, S. C.
 Koopman, Herman W.-----Spartanburg, S. C.
 Kredel, F. E.-----Charleston, S. C.

LaBorde, J. B.-----Columbia, S. C.
 Land, J. N.-----Anderson, S. C.
 Lander, W. T.°-----Williamston, S. C.
 Lassek, Arthur M.-----Charleston, S. C.
 Latimer, J. B.-----Anderson, S. C.
 Laub, G. R.-----Columbia, S. C.
 Law, E. H. (S)-----Columbia, S. C.
 League, J. W., Jr.-----Simpsonville, S. C.
 Ledbetter, F. C.-----Greenville, S. C.
 Lee, D. Lamar-----Florence, S. C.
 Lemmon, C. J.°-----Sumter, S. C.
 Leonard, O. W.°-----Spartanburg, S. C.
 Leonard, Robert W.-----Spartanburg, S. C.
 Lester, W. E.-----Mullins, S. C.
 Lide, C. M. (S)-----Columbia, S. C.
 Lide, L. M.-----Florence, S. C.
 Lindler, C. K.-----Columbia, S. C.
 Linton, I. Grier (S)-----Charleston, S. C.
 Lippert, K. M. (S)-----Lancaster, S. C.
 Lipscombe, J. E. (S)-----Greenville, S. C.
 Lipton, Sidney (S)-----Columbia, S. C.
 Littlejohn, T. R.°-----Sumter, S. C.
 Liverman, J. S.-----Lexington, S. C.
 Livingston, Robert-----Newberry, S. C.
 Loadholt, G. W. I.-----Fairfax, S. C.
 Lominack, R. W.-----Newberry, S. C.
 Long, E. W.-----Columbia, S. C.
 Long, V. A.-----Prosperity, S. C.
 Love, S. G.-----Rock Hill, S. C.
 Lowman, A. W.-----Denmark, S. C.
 Lucas, S. R.-----Florence, S. C.
 Lucas, T. S. (S)-----Charleston, S. C.
 Luttrell, L. W.-----Walterboro, S. C.

Lyday, W. H.-----Greenville, S. C.
 Lyles, W. B.-----Spartanburg, S. C.
 Lynch, Kenneth M.-----Charleston, S. C.
 Lynch, W. S.-----Lake City, S. C.

Mabry, F. L.-----Abbeville, S. C.
 Madden, Ethel Mae-----Columbia, S. C.
 Madden, L. E.-----Columbia, S. C.
 Maddox, Theo°-----Union, S. C.
 Maguire, D. L.°-----Charleston, S. C.
 Maguire, D. L., Jr.-----Charleston, S. C.
 Mamin, Harry (S)-----Columbia, S. C.
 Martin, F. L.-----Mullins, S. C.
 Martin, J. W.-----Anderson, S. C.
 Martin, T. Hutson-----Charleston, S. C.
 Martin, T. Willis-----Belton, S. C.
 Mason, H. E.-----Spartanburg, S. C.
 Mason, R. E.°-----Anderson, S. C.
 Masters, E. W. (S)-----Columbia, S. C.
 Mathias, J. H.-----Lexington, S. C.
 Mathias, M. L.-----Columbia, S. C.
 Matthews, D. N.-----Columbia, S. C.
 May, Charles R., Jr.-----Bennettsville, S. C.
 May, Charles R.°-----Bennettsville, S. C.
 Mayer, O. B. (S)-----Columbia, S. C.
 Mays, W. C.-----Fair Play, S. C.
 Mazyck, McM. K.°-----Charleston, S. C.
 Mead, Walter R.-----Florence, S. C.
 Medlin, Larue Merida-----Charleston, S. C.
 Melich, E. I. (S)-----Columbia, S. C.
 Michaux, D. M.-----Dillon, S. C.
 Michaux, E. B.-----Dillon, S. C.
 Michie, D. E. (S)-----Marion, S. C.
 Mikell, I. J.-----Columbia, S. C.
 Miles, Louis S. (S)-----Summerville, S. C.
 Milford, J. C.-----Anderson, S. C.
 Milford, Lee-----Clemson, S. C.
 Miller, Ben°-----Hickory Grove, S. C.
 Miller, B. N.-----Columbia, S. C.
 Miller, S. E. (S)-----State Park, S. C.
 Milling, C. J.-----Columbia, S. C.
 Mills, W. E.°-----Sumter, S. C.
 Mims, C. W.-----Greenville, S. C.
 Mims, J. Lloyd-----Summerville, S. C.
 Mitchell, J. C.°-----Charleston, S. C.
 Mobley, C. A.-----Orangeburg, S. C.
 Mobley, M. R.-----Florence, S. C.
 Moncrief, W. H.-----State Park, S. C.
 Montgomery, B. M.-----Kingstree, S. C.
 Mood, G. McF.°-----Charleston, S. C.
 Mood, H. A.°-----Sumter, S. C.
 Moore, A. T.-----Columbia, S. C.
 Moore, Charles M.-----Charleston, S. C.
 Moore, E. H.-----Newberry, S. C.
 Moore, George G.-----McColl, S. C.
 Moore, J. C.-----McColl, S. C.
 Moore, J. C.-----Duncan, S. C.
 Moore, M. S.-----Charleston, S. C.
 Moorer, W. M.-----Lodge, S. C.
 Morehouse, W. G. (S)-----Columbia, S. C.
 Morgan, H. B.-----Ware Shoals, S. C.
 Morrall, S. A.-----Graniteville, S. C.
 Morrison, C. W. (S)-----Lancaster, S. C.

Morrow, Sam J.-----Inman, S. C.
 Mosteller, Malcolm-----Columbia, S. C.
 Munro, Catherine N.-----Columbia, S. C.
 Murdoch, J. H., Jr. (S)-----Charleston, S. C.
 Murray, J. G.-----Greenville, S. C.
 McCalla, L. H.-----Greenville, S. C.
 McCants, C. S.-----Winnsboro, S. C.
 McClary, D. R.-----Bishopville, S. C.
 McCord, O. H.-----Woodruff, S. C.
 McCown, B. Uranie-----Charleston, S. C.
 McCurry, W. E.-----Ridge Spring, S. C.
 McCutchen, G. T. (S)-----Columbia, S. C.
 McDaniel, G. E.-----Columbia, S. C.
 MacDonald, Roderick-----Rock Hill, S. C.
 McElroy, A. P.-----Union, S. C.
 McElroy, H. A.-----State Park, S. C.
 McGill, W. K.-----Clover, S. C.
 McGowan, R. P.-----Laurens, S. C.
 McIlwain, W. L.-----Belton, S. C.
 McInnes, B. Kater-----Charleston, S. C.
 MacInnis, Katherine B.-----Columbia, S. C.
 McLawhorn, B. C. (S)-----Greenville, S. C.
 McLean, J. W. (S)-----Greenville, S. C.
 McLendon, S. B.-----Columbia, S. C.
 McLeod, James-----Florence, S. C.
 McMillan, C. B. (S)-----Lake View, S. C.
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 Neidich, Sol (S)-----Beaufort, S. C.
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 Nelson, M. L.-----North, S. C.
 Nesbitt, J. N.°-----Gaffney, S. C.
 Nesbitt, L. T.-----Gaffney, S. C.
 Nevill, P. L.-----Saluda, S. C.
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 Niell, A. Harry-----Clover, S. C.
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 Owens, Jennings K.-----Bennettsville, S. C.
 Owings, F. P. (S)-----Union, S. C.

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 Pearce, James H.-----Pamplico, S. C.
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 Power, J. R.-----Abbeville, S. C.
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 Speissegger, W. H.-----Charleston, S. C.
 Spivey, C. G.-----Columbia, S. C.
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 Stroud, E. C.*-----Marietta, S. C.
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 Stuckey, W. A.-----Sumter, S. C.
 Stukes, L. C.-----Summerton, S. C.

Sturkie, D. R.-----North, S. C.
 Sughrue, John-----Charleston, S. C.
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 Switzer, P. K., Sr.-----Union, S. C.
 Switzer, Paul K., Jr. (S)-----Union, S. C.
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 Symmes, T. H.-----St. Matthews, S. C.

 Taft, Robert B.-----Charleston, S. C.
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 Tuten, W. R.-----Fairfax, S. C.
 Tuten, W. R., Jr.-----Fairfax, S. C.
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 Ulmer, J. G.-----Hemingway, S. C.

 Valley, J. L.*-----Pickens, S. C.
 Valley, T. P. (S)-----Pickens, S. C.
 Van de Erve, J., Jr.-----Charleston, S. C.
 Varner, J. W.-----Columbia, S. C.
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 VonLehe, J. A.-----Walterboro, S. C.

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 Watkins, John O. (S)-----Spartanburg, S. C.
 Watson, A. C.-----Greenville, S. C.
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 Watson, Paul S.-----Kingstree, S. C.
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 Webb, J. N.-----Seneca, S. C.
 Webb, M. W.-----Wagener, S. C.
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 Wellbrock, W. L. A. (S)-----Charleston, S. C.
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 Wertz, J. A.-----Estill, S. C.
 West, C. A.-----Camden, S. C.
 Weston, I'On (S)-----Mullins, S. C.
 Weston, William°-----Columbia, S. C.
 Weston, William, Jr.-----Columbia, S. C.
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 Whetsell, W. O.-----Orangeburg, S. C.
 Whitaker, A. B. (S)-----Camden, S. C.
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 Whitehead, J. D.-----Lake City, S. C.
 Whitley, Walter E.-----Andrews, S. C.
 Whitten, B. O.-----Clinton, S. C.
 Whitworth, Horace (S)-----Greenville, S. C.
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 Wilds, E. L. (S)-----Anderson, S. C.
 Wilds, R. H.-----Aiken, S. C.
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 Willcox, J. M.-----Darlington, S. C.
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 Willis, Henry A.-----Moncks Corner, S. C.

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McCrady, R. L.	Funderburke, I. S.	Callison, H. G.
McInnes, B. Kater	Harrison, J. P.	Carrigan, G. B.
Medlin, LaRue Merida	Hook, M. W.	Chappell, B. S. (S)
Mitchell, J. C. °	Purvis, O. H.	Cheatham, M. W.
Mood, G. McF. °	CHESNEE	Coffee, H. D.
Moore, Charles M.	Cash, J. B.	Coleman, F. P. (S)
Moore, M. S.	Reid, S. D.	Cook, W. C.
Murdoch, J. H., Jr. (S)	Ryan, T. P.	Corbett, W. M., Jr.
O'Driscoll, W. C. °	CHESTER	Cuttino, J. T. (S)
O'Hear, James, Jr. (S)	Chance, F. S. (S)	Davis, J. M. (S)
Parker, Edward F. (S)	Gaston, J. N., Jr.	Davis, L. C.
Pettus, W. J.	Hennies, Geo. A.	Dillard, J. A.
Postoloff, Anthony V.	Henry, W. J.	Dotterer, T. D. (S)
Pratt Thomas, H. R.	Hicks, R. D.	Doughty, R. G.
Price, F. R.	Patterson, V. P.	Dove, H. R.
Price, Wm. H.	Wallace, W. R.	Dubose, T. M., Jr.
Pringle, Duncan	Young, J. P. °	Durham, I. D.
Pringleau, Wm. H.	Wylie, A. M. °	Durham, R. B.
Prystowsky, Sidney	CHESTERFIELD	Durst, George G. (S)
Ravenel, B. Owen	Perry, Wm. L.	Eaddy, A. M. (S)
Ravenel, James J.	Wiley, W. R.	Epting, C. H.
Ravenel, W. Jervey	Perry, W. J. °	Eskrigge, Edith
Remsen, D. B.	CLEMSON	Fishburn, S. B. °
Reynolds, T. W. (S)	Milford, Lee	Fouche, J. S.
Rhame, J. S.	CLIFTON	Fouche, J. W. (S)
Rhett, Wm. P.	Koopman, Herman W.	Fox, W. M. (S)
Rhett, Wythe M.	CLINTON	Freed, J. E. (S)
Richards, G. P.	Anderson, C. W. (S)	Fulmer, W. E. °
Rivers, Arthur L.	Davis, J. W. °	Geiger, F. L.
Robertson, H. C., Jr. (S)	Graham, B. (S)	George, W. E.
Rudisill, Hillyer	Hays, S. C.	Gibbes, J. H.
Sanders, P. W., Jr.	Rhame, D. O.	Gibbes, R. W. °
Scharlock, T. M. °	Shealy, F. K.	Green, J. T. (S)
Scott, James E.	Whitten, B. O.	Griffin, H. H. °
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Settle, John M.	CLIO	Guigner, J. B. °
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Smith, J. E.	McGill, W. K.	Hall, L. F.
Smith, Wm. A.	Niell, A. H.	Hall, W. S. (S)
Smithy, Horace G.	COLUMBIA	Ham, Coyt
Sparkman, E. H. ° (S)	Abel, T. D.	Hamilton, R. G.
Speisseger, C. A. °	Abel, W. C. °	Hart, W. A.
Speisseger, W. H.	Adams, E. C. L. °	Hayne, J. Adams °
Steinberg, Matthew	Adcock, D. F.	Heyward, N. B.
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Taft, Robert B.	Allison, J. R.	Hopkins, T. J.
Taylor, Guy F.	Asbill, D. S. (S)	Hutchinson, M. E. (S)
Townsend, E. W. (S)	Ball, R. W. (S)	Johnson, H. M.
Townsend, John F. °	Barnett, Roy	Josey, A. I. (S)
Van De Erve, J., Jr.	Barron, E. W.	Josey, R. B. (S)
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Waring, Joe I.	Barron, W. T. (S)	Kibler, C. L. °
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 MacInnis, Katherine B.
 Madden, Ethel Mae
 Madden, L. E.
 Mamin, Harry (S)
 Masters, E. W. (S)
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 Mayer, O. B. (S)
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 Mosteller, Malcolm
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 Pitts, T. A.
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 Shaw, J. G. (S)
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 Wyman, M. H.^o
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 Smith, Hugh (S)
 Smith, Keitt (S)
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 Ulmer, J. G.

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 Miller, Ben °

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Danner, J. H.
 Goodwin, C. I.
 Wells, Leon
 HONEA PATH
 Haynie, Jas. Wm.
 Stoudemire, D. C.

HOPKINS

Claytor, H. °

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Morrow, Sam J.

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 Tucker, E. W.

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Blackmon, S. J.
 Brewer, J. M. (S)

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 Montgomery, B. M.
 Ravenel, L. J.
 Watson, Paul S.

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 Evans, Dexter M.
 King, H. B.
 Lynch, W. S.
 Whitehead, J. D.
 Williams, E. M.

LAKE VIEW

Elvington, R. F.
 McMillan, C. B. (S)
 Temple, L. W.

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 Crawford, R. L.
 Crawley, W. G. (S)
 Harris, J. C.
 Lippert, K. M. (S)
 Noel, C. T.
 Pittman, J. D.

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Bethea, W. S. (S)
 Carpenter, F. L.
 Edwards, H. A.

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Ariail, R. H.
 Hart, John G.
 McGowan, R. P.
 Nickles, M. B.
 Teague, M. M. (S)
 Vincent, C. P.

LEESVILLE

Able, Karl L.
 Crosson, James
 Holley, O. C.
 Keisler, D. S.

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 Mathias, J. H.

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LODGE
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 Thomas, J. D.
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 Keels, L. B. (S)
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 Harvin, W. S.
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MARION
 Dibble, E. M.°
 Finger, Elliott (S)
 Hankins, T. C. (S)
 Johnson, Joseph Allen
 Michie, D. E. (S)
MARTIN'S POINT
 Barnwell, E. H. (S)
McCOLL
 Buckner, Margaret
 Moore, G. G.
 Moore, J. C.
McCORMICK
 Workman, C. H.
MONCK'S CORNER
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 Walsh, J. N.
 Willis, H. A.
MT. PLEASANT
 Frannmpton, James°
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 Bullock, C. T.
 Cain, J. P., Jr.
 Lester, W. E.
 Martin, F. L.
 Weston, I'On (S)
MYRTLE BEACH
 Rourk, M. H. (S)
 Rourk, W. A.
NEESES
 Connor, P. M.
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 Able, E. G.
 Houseal, R. W. (S)
 Livingston, Robert
 Moore, E. H.
 Neely, A. T.
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 Sease, J. C.
 Senn, H. B.
 Welling, A. W. (S)
NICHOLS
 Gilmore, H. S.
NINETY SIX
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 Schneider, L. A. (S)
NORTH

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 Nelson, M. L.
 Sturkie, D. R.
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 Floyd, L. C.
 Thomason, E. H. (S)
OLAR
 Hartzog, L. G.°
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 Bolin, G. C.
 Brabham, V. W.
 Brabham, V. W., Jr.
 Cone, Preston
 Culler, O. Z.
 Eargle, H. M.
 Gressette, J. H.
 Harter, J. W. (S)
 Mobley, C. A.
 Shecut, L. C.°
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 Truluck, G. M.
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 Willis, A. E.
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 Hill, Robert D.
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 Griggs, D. C.
PAMPLICO
 Pearce, James H.
 Poston, W. H.
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 Pinner, C. A.
PELION
 Hutto, A. T.
PELZER
 Dendy, W. S.
 Goodlett, O. M., Jr.
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 Horton, C. C.
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 Cannon, E. G.
 Valley, J. L.°
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 Woodruff, P. E. (S)
PIEDMONT
 Campbell, S. D.
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 Ryan, C. P.
RIDGE SPRING
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 McCurry, W. E.
RIDGEWAY
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 Bigger, D. A.
 Blackmon, W. R.
 Bratton, J. R. (S)
 Bundy, J. L.
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 Gaston, F. P. (S)
 Herlong, E. E.
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 Love, S. G.
 MacDonald, Roderick
 Quantz, N. G.
 Seigle, B. I. (S)
 Shippey, S. H.
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 Strait, W. F.
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RUFFIN
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 Cochran, E. D. (S)
 Cochran, Wm. N.
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 Leonard, O. W.^o
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 Switzer, Paul K., Sr.
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